

2015 Aetna Pharmacy Plan Drug List - Premier

# Abilify

---

**Products Affected**

- ABILIFY ORAL TABLET

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

# Abilify

---

## Products Affected

- ABILIFY ORAL SOLUTION

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

# Abilify Discmelt

---

## Products Affected

- ABILIFY DISCMELT

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

# Abilify Maintena

---

## Products Affected

- ABILIFY MAINTENA

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

# Absorica

## Products Affected

- ABSORICA

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria: 1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Abstral

## Products Affected

- ABSTRAL

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

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

<b>ST Criteria</b>	A documented contraindication or intolerance or allergy or failure of an adequate trial of one week each of the preferred generic alternative, fentanyl transmucosal lozenge AND two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
<b>QL Criteria</b>	15 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Acanya

---

## Products Affected

- ACANYA

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



# Accu-Chek Active

---

## Products Affected

- ACCU-CHEK ACTIVE

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

# Accu-Chek Aviva

---

## Products Affected

- ACCU-CHEK AVIVA IN VITRO STRIP

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

# Accu-Chek Aviva Plus

---

## Products Affected

- ACCU-CHEK AVIVA PLUS IN VITRO

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

# Accu-Chek Comfort Curve

---

## Products Affected

- ACCU-CHEK COMFORT CURVE IN VITRO STRIP

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

# Accu-Chek Compact

---

## Products Affected

- ACCU-CHEK COMPACT

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

# Accu-Chek Compact Plus

---

## Products Affected

- ACCU-CHEK COMPACT PLUS

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

# Accu-Chek Compact Test Drum

---

## Products Affected

- ACCU-CHEK COMPACT TEST DRUM

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

# Accu-Chek SmartView

---

## Products Affected

- ACCU-CHEK SMARTVIEW

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



# Accutrend Glucose

---

## Products Affected

- ACCUTREND GLUCOSE

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

# Aciphex

---

## Products Affected

- ACIPHEX

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(1) Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: (a) The heartburn can be controlled by use of OTC medications, and (b) There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis, and (c) There are no symptoms of a more complicated GI condition (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), OR (2) Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications, OR (3) Any of the following diagnoses when NOT in combination with a diagnosis listed above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: (a) Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal) and (b) Member is experiencing acid breakthrough, OR (c) Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. **NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.</p>

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

<b>ST Criteria</b>	Trial of ONEmonth each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AcipHex Sprinkle

---

## Products Affected

- ACIPHEX SPRINKLE

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

# Actiq

---

## Products Affected

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

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Breakthrough cancer pain, General anesthesia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)AND Documentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process</p>
<b>ST Criteria</b>	A documented contraindication or intolerance or allergy or failure of an adequate trial of one week each of the preferred generic alternative, fentanyl transmucosal lozenge AND two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
<b>QL Criteria</b>	15 lollipops Per 30 days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Activella

---

## Products Affected

- ACTIVELLA

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



# Actonel

---

## Products Affected

- ACTONEL ORAL TABLET 150 MG

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

# Actonel

---

## Products Affected

- ACTONEL ORAL TABLET 35 MG

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

# Actonel

---

## Products Affected

- ACTONEL ORAL TABLET 5 MG, 30 MG

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

# Actoplus Met

---

## Products Affected

- ACTOPLUS MET

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

# Actoplus met XR

---

## Products Affected

- ACTOPLUS MET XR

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

# Actos

---

## Products Affected

- ACTOS

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

# Acular

---

## Products Affected

- ACULAR

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

# Acular LS

---

**Products Affected**

- ACULAR LS

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



# Acura Blood Glucose Test

---

## Products Affected

- ACURA BLOOD GLUCOSE TEST

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

# Acuvail

---

## Products Affected

- ACUVAIL

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

# Adcirca

---

## Products Affected

- ADCIRCA

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

# Adderall

## Products Affected

- ADDERALL ORAL TABLET 20 MG

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

# Adderall

## Products Affected

- ADDERALL ORAL TABLET 30 MG, 7.5 MG, 10 MG, 12.5 MG, 15 MG, 5 MG

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

# Adderall XR

## Products Affected

- ADDERALL XR

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

# Adempas

---

## Products Affected

- ADEMPAS

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

# Adrenaclick

## Products Affected

- ADRENACLICK

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



# Advair Diskus

---

## Products Affected

- ADVAIR DISKUS

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

# Advair HFA

---

## Products Affected

- ADVAIR HFA

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

# Advance Intuition Test

---

## Products Affected

- ADVANCE INTUITION TEST

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

# Advance Micro-Draw Test

---

## Products Affected

- ADVANCE MICRO-DRAW TEST

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

# Advicor

---

## Products Affected

- ADVICOR

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

# Advocate Redi-Code

---

## Products Affected

- ADVOCATE REDI-CODE IN VITRO

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

# Advocate Redi-Code+ Test

---

## Products Affected

- ADVOCATE REDI-CODE+ TEST

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

# Advocate Test

---

## Products Affected

- ADVOCATE TEST

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



# Aerospan

---

## Products Affected

- AEROSPAN

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

# Afinitor

---

## Products Affected

- AFINITOR

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

# Afinitor Disperz

---

## Products Affected

- AFINITOR DISPERZ

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

# Afrezza

## Products Affected

- AFREZZA

PA Criteria	Criteria Details
Covered Uses	Diagnosis of type 1 or type 2 Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	Documentation of ALL of the following:1) In patients with type 1 diabetes, concomitant use of long-acting insulin (e.g., Levamir or Lantus).2) In all Patients: No history of chronic lung disease such as asthma or Chronic Obstructive Pulmonary Disease (COPD).3) Detailed medical history documenting physical examination and spirometry (FEV1) to identify potential lung disease in all patients.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	ALL: Trial of one month of one alternative rapid-acting insulin (Humulin OR Humalog)
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# AgaMatrix AMP Test

---

## Products Affected

- AGAMATRIX AMP TEST

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

# AgaMatrix Jazz Test

---

## Products Affected

- AGAMATRIX JAZZ TEST

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

# AgaMatrix KeyNote Test

---

## Products Affected

- AGAMATRIX KEYNOTE TEST

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

# AgaMatrix Presto Test

---

## Products Affected

- AGAMATRIX PRESTO TEST

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



# Akynzeo

---

## Products Affected

- AKYNZEO

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

# Albertsons Test

---

## Products Affected

- *albertsons test*

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

# Aldara

---

## Products Affected

- ALDARA

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

# Alendronate Sodium

---

## Products Affected

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

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

# Alendronate Sodium

---

## Products Affected

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

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

# Alfuzosin HCl ER

## Products Affected

- *alfuzosin hcl er*

PA Criteria	Criteria Details
Covered Uses	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	Member?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Almotriptan Malate

---

## Products Affected

- *almotriptan malate*

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

# Alora

---

## Products Affected

- ALORA

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



# ALPRAZolam ER

---

## Products Affected

- *alprazolam er*

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

# ALPRAZolam XR

---

## Products Affected

- *alprazolam xr*

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

# Alsuma

---

## Products Affected

- ALSUMA

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

# Altavera

---

## Products Affected

- ALTAVERA

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

# Altoprev

---

## Products Affected

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

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

# Altoprev

---

## Products Affected

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

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

# Alvesco

---

## Products Affected

- ALVESCO

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

# Alyacen 1/35

---

## Products Affected

- *alyacen 1/35*

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



# Alyacen 7/7/7

---

## Products Affected

- *alyacen 7/7/7*

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

# Ambien

---

## Products Affected

- AMBIEN ORAL TABLET 10 MG

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

# Ambien

---

## Products Affected

- AMBIEN ORAL TABLET 5 MG

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

# Ambien CR

---

## Products Affected

- AMBIEN CR

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

# Amerge

---

## Products Affected

- AMERGE

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

# Amethia

---

## Products Affected

- AMETHIA

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

# Amethia Lo

---

## Products Affected

- AMETHIA LO

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

# Amitiza

---

## Products Affected

- AMITIZA

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



# Amlodipine Besylate-Valsartan

---

## Products Affected

- *amlodipine besylate-valsartan*

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

# Amnesteem

## Products Affected

- AMNESTEEM

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria: 1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Amphetamine-Dextroamphet ER

---

## Products Affected

- *amphetamine-dextroamphet er*

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

# Amphetamine-Dextroamphetamine

---

## Products Affected

- *amphetamine-dextroamphetamine oral tablet*  
20 mg

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

# Amphetamine-Dextroamphetamine

---

## Products Affected

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

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

# Ampyra

---

## Products Affected

- AMPYRA

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

# Amrix

---

## Products Affected

- AMRIX

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

# Amturnide

---

## Products Affected

- AMTURNIDE

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



# Androderm

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	1 patch Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

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

# AndroGel

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	30 packs Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

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

# AndroGel

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	60 packs Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# AndroGel

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	30 pack Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

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

# AndroGel Pump

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# AndroGel Pump

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

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

# Angeliq

---

## Products Affected

- ANGELIQ

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

# Angeliq

---

## Products Affected

- ANGELIQ

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



# Anoro Ellipta

---

## Products Affected

- ANORO ELLIPTA

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

# Antara

---

## Products Affected

- ANTARA

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

# Antibiotic Ear

---

## Products Affected

- *antibiotic ear*

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

# Anzemet

---

## Products Affected

- ANZEMET ORAL

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

# APAP-Caff-Dihydrocodeine

---

## Products Affected

- *apap-caff-dihydrocodeine oral capsule*

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

# Aplenzin

---

## Products Affected

- APLENZIN

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

# Apri

---

## Products Affected

- APRI

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

# Apriso

---

## Products Affected

- APRISO

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



# Aptensio XR

## Products Affected

- APTENSIO XR

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

# Aptiom

---

## Products Affected

- APTIOM ORAL TABLET 800 MG, 400 MG, 200 MG

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

# Aptiom

---

## Products Affected

- APTIOM ORAL TABLET 600 MG

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

# Aralen

---

## Products Affected

- ARALEN

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

# Aranelle

---

## Products Affected

- ARANELLE

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

# Arcapta Neohaler

---

## Products Affected

- ARCAPTA NEOHALER

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

# Aricept

---

## Products Affected

- ARICEPT

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

# Aricept ODT

---

## Products Affected

- ARICEPT ODT

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



# ARIPiprazole

---

## Products Affected

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

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

# ARIPiprazole

---

## Products Affected

- *aripiprazole oral solution*

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

# Arnuity Ellipta

## Products Affected

- ARNUITY ELLIPTA

PA Criteria	Criteria Details
Covered Uses	Asthma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial and failure of TWO of THREE (Asmanex, Qvar, OR Flovent)
QL Criteria	1 blister Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Asacol HD

---

## Products Affected

- ASACOL HD

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

# Assure 3 Test

---

## Products Affected

- ASSURE 3 TEST

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

# Assure 4 Test

---

## Products Affected

- ASSURE 4 TEST

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

# Assure II

---

## Products Affected

- ASSURE II

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

# Assure II Check

---

## Products Affected

- ASSURE II CHECK

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



# Assure Platinum

---

## Products Affected

- ASSURE PLATINUM

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

# Assure Pro Test

---

## Products Affected

- ASSURE PRO TEST

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

# At Last Test

---

## Products Affected

- AT LAST TEST

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

# Atacand

---

## Products Affected

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

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

# Atacand HCT

## Products Affected

- ATACAND HCT ORAL TABLET 16-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	2 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Atacand HCT

## Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Atelvia

---

## Products Affected

- ATELVIA

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

# Atorvastatin Calcium

---

## Products Affected

- *atorvastatin calcium oral*

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



# Atovaquone-Proguanil HCl

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Malaria
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of malaria
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Malaria: 30 days Other Diagnosis: 1 year
<b>Other Criteria</b>	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Atralin

## Products Affected

- ATRALIN

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following:Acne vulgaris (includes comedonal, cystic, nodular & papular acne)Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of two preferred alternatives indicated for the member's condition, one of which has to be tretinoin.
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Aubagio

---

## Products Affected

- AUBAGIO

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

# Aubra

---

## Products Affected

- AUBRA

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

# Avalide

## Products Affected

- AVALIDE ORAL TABLET 150-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Avalide

## Products Affected

- AVALIDE ORAL TABLET 300-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Avapro

## Products Affected

- AVAPRO ORAL TABLET 75 MG, 150 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis Hypertension or Diabetic nephropathy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Avapro

## Products Affected

- AVAPRO ORAL TABLET 300 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis Hypertension or Diabetic nephropathy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/References	
Revision Date	Prior Authorization: November 24, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Aviane

---

## Products Affected

- AVIANE

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

# Avidoxy

## Products Affected

- *avidoxy*

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

# AVINza

## Products Affected

- AVINZA

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

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

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

# Avodart

## Products Affected

- AVODART

PA Criteria	Criteria Details
Covered Uses	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	For coverage in females members:Member is NOT pregnantANDMember?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Axert

---

## Products Affected

- AXERT

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

# Axiron

## Products Affected

- AXIRON

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	6 ML Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# AzaSite

---

## Products Affected

- AZASITE

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



# Azilect

---

## Products Affected

- AZILECT

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

# Azor

## Products Affected

- AZOR

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

# Azulfidine

---

## Products Affected

- AZULFIDINE

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

# Azulfidine EN-tabs

---

## Products Affected

- AZULFIDINE EN-TABS

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

# Azurette

---

## Products Affected

- AZURETTE

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

# Balsalazide Disodium

---

## Products Affected

- *balsalazide disodium*

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

# Balziva

---

## Products Affected

- BALZIVA

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

# Banzel

---

## Products Affected

- BANZEL ORAL TABLET

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



# Bayer Contour Next Test

---

## Products Affected

- BAYER CONTOUR NEXT TEST

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

# Bayer Contour Test

---

## Products Affected

- BAYER CONTOUR TEST

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

# BD Test

---

## Products Affected

- BD TEST

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

# Beconase AQ

---

## Products Affected

- BECONASE AQ

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

# Belsomra

---

## Products Affected

- BELSOMRA

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

# Benicar

## Products Affected

- BENICAR ORAL TABLET 20 MG, 5 MG

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

# Benicar

## Products Affected

- BENICAR ORAL TABLET 40 MG

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

# Benicar HCT

## Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Benicar HCT

## Products Affected

- BENICAR HCT ORAL TABLET 20-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Benzamycin

---

## Products Affected

- BENZAMYCIN

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

# BenzamycinPak

---

## Products Affected

- BENZAMYCINPAK

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

# BG Star Test

---

## Products Affected

- BG STAR TEST

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

# Bicalutamide

## Products Affected

- *bicalutamide*

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

# Bimatoprost

---

## Products Affected

- *bimatoprost ophthalmic*

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

# Binosto

---

## Products Affected

- BINOSTO

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

# Bioscanner Glucose Test

---

## Products Affected

- BIOSCANNER GLUCOSE TEST

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



# BL Test Strip Pack

---

## Products Affected

- *bl test strip pack*

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

# Blephamide

---

## Products Affected

- BLEPHAMIDE

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

# Blood Glucose Test

---

## Products Affected

- *blood glucose test*

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

# Boniva

---

## Products Affected

- BONIVA ORAL

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

# Breo Ellipta

---

## Products Affected

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

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

# Breo Ellipta

## Products Affected

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

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

# Briellyn

---

## Products Affected

- *briellyn*

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

# Brilinta

---

## Products Affected

- BRILINTA

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



# Brilinta

---

## Products Affected

- BRILINTA

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

# Brintellix

---

## Products Affected

- BRINTELLIX

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

# Brovana

---

## Products Affected

- BROVANA

<b>QL Criteria</b>	60 vials (120ml) Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Budeprion SR

---

## Products Affected

- BUDEPRION SR

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

# Budeprion XL

---

## Products Affected

- BUDEPRION XL

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

# Budesonide

---

## Products Affected

- *budesonide inhalation suspension 1 mg/2ml*

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

# Budesonide ER

---

## Products Affected

- *budesonide er*

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

# Bunavail

---

## Products Affected

- BUNAVAIL BUCCAL FILM 6.3-1 MG

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



# Bunavail

---

## Products Affected

- BUNAVAIL BUCCAL FILM 2.1-0.3 MG

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

# Bunavail

---

## Products Affected

- BUNAVAIL BUCCAL FILM 4.2-0.7 MG

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

# Buprenorphine HCl

---

## Products Affected

- *buprenorphine hcl sublingual tablet sublingual*  
2 mg

<b>QL Criteria</b>	24 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Buprenorphine HCl

---

## Products Affected

- *buprenorphine hcl sublingual tablet sublingual*  
8 mg

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

# Buprenorphine HCl-Naloxone HCl

---

## Products Affected

- *buprenorphine hcl-naloxone hcl*

<b>QL Criteria</b>	90 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# BuPROPion HCl

---

## Products Affected

- *bupropion hcl oral*

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

## BuPROPion HCl ER (Smoking Det)

---

### Products Affected

- *bupropion hcl er (smoking det)*

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

## BuPROPion HCl ER (SR)

---

### Products Affected

- *bupropion hcl er (sr)*

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



## BuPROPion HCl ER (XL)

---

### Products Affected

- *bupropion hcl er (xl)*

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

# Butorphanol Tartrate

---

## Products Affected

- *butorphanol tartrate nasal*

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

# Butrans

---

## Products Affected

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

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

# Butrans

---

## Products Affected

- BUTRANS TRANSDERMAL PATCH  
WEEKLY 7.5 MCG/HR

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

# Bydureon

---

## Products Affected

- BYDUREON

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

# Bydureon

---

## Products Affected

- BYDUREON

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

# Byetta 10 MCG Pen

---

## Products Affected

- BYETTA 10 MCG PEN

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

# Byetta 5 MCG Pen

---

## Products Affected

- BYETTA 5 MCG PEN

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



## Calcitonin (Salmon)

---

### Products Affected

- *calcitonin (salmon)*

<b>QL Criteria</b>	0.12 ML Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Cambia

---

## Products Affected

- CAMBIA

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

# Camila

---

## Products Affected

- CAMILA

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

# Camrese

---

## Products Affected

- CAMRESE

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

# Camrese Lo

---

## Products Affected

- CAMRESE LO

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

# Canasa

---

## Products Affected

- CANASA

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

# Candesartan Cilexetil

---

## Products Affected

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

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

# Candesartan Cilexetil-HCTZ

---

## Products Affected

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

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



# Caprelsa

---

## Products Affected

- CAPRELSA

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

# CareOne Blood Glucose Test

---

## Products Affected

- CAREONE BLOOD GLUCOSE TEST

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

# CareSens N Glucose Test

---

## Products Affected

- CARESENS N GLUCOSE TEST

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

# Casodex

## Products Affected

- CASODEX

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

# Caziant

---

## Products Affected

- CAZIAN T

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

# CeleBREX

---

## Products Affected

- CELEBREX ORAL CAPSULE 200 MG

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

# CeleBREX

---

## Products Affected

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

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

# Celecoxib

---

## Products Affected

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

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



# Celecoxib

---

## Products Affected

- *celecoxib oral capsule 200 mg*

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

# CeleXA

---

## Products Affected

- CELEXA

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

# Cenestin

---

## Products Affected

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

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

# Cerdelga

---

## Products Affected

- CERDELGA

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

# Cesamet

---

## Products Affected

- CESAMET

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

# Cesia

---

## Products Affected

- CESIA

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

# Chantix

---

## Products Affected

- CHANTIX

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

# Chantix Continuing Month Pak

---

## Products Affected

- CHANTIX CONTINUING MONTH PAK

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



# Chantix Starting Month Pak

---

## Products Affected

- CHANTIX STARTING MONTH PAK

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

# Chateal

---

## Products Affected

- CHATEAL

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

# Chloroquine Phosphate

---

## Products Affected

- *chloroquine phosphate oral*

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

# Choice DM Fora G20 Test Strips

---

## Products Affected

- CHOICE DM FORA G20 TEST STRIPS

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

# Ciclodan

## Products Affected

- CICLODAN EXTERNAL SOLUTION

PA Criteria	Criteria Details
<b>Covered Uses</b>	Onychomycosis due to dermatophyte
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (positive test should be recent (within the last 3 - 6 months) and associated with the current infection) and, (2) a documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative either terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), fluconazole (6 months), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail) OR presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis) OR member is female and is pregnant and/or breastfeeding, and (3) Member is NOT receiving a systemic (oral) antifungal agent - terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step therapy applies
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ciclopirox

## Products Affected

- *ciclopirox external solution*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Onychomycosis due to dermatophyte
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (positive test should be recent (within the last 3 - 6 months) and associated with the current infection) and, (2) a documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative either terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), fluconazole (6 months), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail) OR presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis) OR member is female and is pregnant and/or breastfeeding, and (3) Member is NOT receiving a systemic (oral) antifungal agent - terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step therapy applies
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ciloxan

---

## Products Affected

- CILOXAN OPHTHALMIC SOLUTION

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

# Cipro

## Products Affected

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

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



# Cipro HC

---

## Products Affected

- CIPRO HC

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

# Cipro XR

## Products Affected

- CIPRO XR

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

# Ciprodex

---

## Products Affected

- CIPRODEX

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

# Ciprofloxacin HCl

---

## Products Affected

- *ciprofloxacin hcl ophthalmic*

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

# Ciprofloxacin HCl

## Products Affected

- *ciprofloxacin hcl oral*

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

# Ciprofloxacin-Ciproflox HCl ER

## Products Affected

- *ciprofloxacin-ciproflox hcl er*

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

# Citalopram Hydrobromide

---

## Products Affected

- *citalopram hydrobromide oral tablet*

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

# Claravis

## Products Affected

- CLARAVIS

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria: 1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Clarinet

## Products Affected

- CLARINEX ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than / = 2 years of age - For Clarinet and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinet, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	1 tab Per 1 Day
Notes/References	

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

# Clarinet

## Products Affected

- CLARINEX ORAL SYRUP

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than $\neq$ 2 years of age - For Clarinet and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinet, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	10 ml Per 1 Day
Notes/References	

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

# Clarinet Reditabs

## Products Affected

- CLARINEX REDITABS

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than / = 2 years of age - For Clarinet and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinet, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	1 tab Per 1 Day
Notes/References	

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

# Clarinet-D 12 Hour

## Products Affected

- CLARINEX-D 12 HOUR

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than $\neq$ 2 years of age - For Clarinet and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinet, desloratadine and fexofenadine are designated as Pregnancy Category C
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/References</b>	

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



# Clarinet-D 24 Hour

## Products Affected

- CLARINEX-D 24 HOUR

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than $\neq$ 2 years of age - For Clarinet and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinet, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	1 tab Per 1 Day
Notes/References	

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

# Clever Chek Auto-Code Test

---

## Products Affected

- CLEVER CHEK AUTO-CODE TEST

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

# Clever Chek Auto-Code Voice

---

## Products Affected

- CLEVER CHEK AUTO-CODE VOICE IN VITRO

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

# Clever Chek Test

---

## Products Affected

- CLEVER CHEK TEST

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

# Clever Choice Auto-Code Test

---

## Products Affected

- CLEVER CHOICE AUTO-CODE TEST

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

# Clever Choice Micro Test

---

## Products Affected

- CLEVER CHOICE MICRO TEST

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

# Climara

---

## Products Affected

- CLIMARA

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



# Climara Pro

---

## Products Affected

- CLIMARA PRO

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

# Clobex

---

## Products Affected

- CLOBEX

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

# CloNIDine HCl ER

---

## Products Affected

- *clonidine hcl er*

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

# Clopidogrel Bisulfate

---

## Products Affected

- *clopidogrel bisulfate oral tablet 75 mg*

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

# CloZAPine

---

## Products Affected

- *clozapine oral tablet 25 mg, 50 mg*

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

# CloZAPine

---

## Products Affected

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

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

# CloZAPine

---

## Products Affected

- *clozapine oral tablet 100 mg*

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

# CloZAPine

---

## Products Affected

- *clozapine oral tablet dispersible 150 mg*

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



# Clozaril

---

## Products Affected

- CLOZARIL ORAL TABLET 100 MG

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

# Clozaril

---

## Products Affected

- CLOZARIL ORAL TABLET 25 MG

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

# Coartem

## Products Affected

- COARTEM

PA Criteria	Criteria Details
<b>Covered Uses</b>	Malaria
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of malaria
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Malaria: 30 days Other Diagnosis: 1 year
<b>Other Criteria</b>	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Colazal

---

## Products Affected

- COLAZAL

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

# Colcrlys

---

## Products Affected

- COLCRYS

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

# Coly-Mycin S

---

## Products Affected

- COLY-MYCIN S

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

# CombiPatch

---

## Products Affected

- COMBIPATCH

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

# Combivir

---

## Products Affected

- COMBIVIR

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



## Cometriq (100 mg Daily Dose)

---

### Products Affected

- COMETRIQ (100 MG DAILY DOSE)

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

## Cometriq (140 mg Daily Dose)

---

### Products Affected

- COMETRIQ (140 MG DAILY DOSE)

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

## Cometriq (60 mg Daily Dose)

---

### Products Affected

- COMETRIQ (60 MG DAILY DOSE)

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

# Concerta

## Products Affected

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

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

# Concerta

## Products Affected

- CONCERTA ORAL TABLET  
EXTENDEDRELEASE\* 36 MG

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

# Control AST

---

## Products Affected

- CONTROL AST

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

# Control Test

---

## Products Affected

- CONTROL TEST

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

# ConZip

---

## Products Affected

- CONZIP

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



# Corlanor

## Products Affected

- CORLANOR

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

# Cortisporin

---

## Products Affected

- CORTISPORIN OTIC

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

# Cortisporin-TC

---

## Products Affected

- CORTISPORIN-TC

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

# Cozaar

## Products Affected

- COZAAR ORAL TABLET 25 MG, 50 MG

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

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

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

# Crestor

---

## Products Affected

- CRESTOR

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

# Cryselle-28

---

## Products Affected

- CRYSELLE-28

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

# Cutivate

---

## Products Affected

- CUTIVATE

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



# CVS Blood Glucose Test

---

## Products Affected

- *cvs blood glucose test*

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

# Cyclafem 1/35

---

## Products Affected

- CYCLAFEM 1/35

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

# Cyclafem 7/7/7

---

## Products Affected

- CYCLAFEM 7/7/7

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

# Cymbalta

---

## Products Affected

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

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

# Cymbalta

---

## Products Affected

- CYMBALTA ORAL CAPSULE DELAYED  
RELEASE PARTICLES 60 MG

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

# Daklinza

---

## Products Affected

- DAKLINZA

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

# Daraprim

---

## Products Affected

- DARAPRIM

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

# Dasetta 1/35

---

## Products Affected

- DASETTA 1/35

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



# Dasetta 7/7/7

---

## Products Affected

- DASETTA 7/7/7

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

# Daysee

---

## Products Affected

- DAYSEE

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

# Daytrana

## Products Affected

- DAYTRANA

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

# Delzicol

---

## Products Affected

- DELZICOL

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

# Demeclocycline HCl

## Products Affected

- *demeclocycline hcl oral*

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

# Depo-Provera

---

## Products Affected

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

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

# Depo-SubQ Provera 104

---

## Products Affected

- DEPO-SUBQ PROVERA 104

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

# Desloratadine

## Products Affected

- *desloratadine*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than $\geq 2$ years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	



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

# Desogestrel-Ethinyl Estradiol

---

## Products Affected

- *desogestrel-ethinyl estradiol*

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

# Desonate

---

## Products Affected

- DESONATE

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

# Desoxyn

## Products Affected

- DESOXYN

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

# Detrol

---

## Products Affected

- DETROL

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

# Detrol LA

---

## Products Affected

- DETROL LA

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

# Dexedrine

---

## Products Affected

- DEXEDRINE ORAL TABLET

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

# Dexedrine

## Products Affected

- DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR

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



# Dexilant

---

## Products Affected

- DEXILANT

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

# Dexmethylphenidate HCl

---

## Products Affected

- *dexmethylphenidate hcl*

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

# Dexmethylphenidate HCl ER

---

## Products Affected

- *dexmethylphenidate hcl er*

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

# Dexmethylphenidate HCl ER

---

## Products Affected

- *dexmethylphenidate hcl er*

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

# Dextroamphetamine Sulfate

---

## Products Affected

- *dextroamphetamine sulfate oral tablet*

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

# Dextroamphetamine Sulfate

---

## Products Affected

- *dextroamphetamine sulfate oral solution*

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

# Dextroamphetamine Sulfate ER

---

## Products Affected

- *dextroamphetamine sulfate er*

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

# Diabetic.com Test

---

## Products Affected

- *diabetic.com test*

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



# Diastat AcuDial

---

## Products Affected

- DIASTAT ACUDIAL

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

# Diastat Pediatric

---

## Products Affected

- DIASTAT PEDIATRIC

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

# DiaTrue Plus Test

---

## Products Affected

- *diatruue plus test*

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

# Diclegis

---

## Products Affected

- DICLEGIS

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

# Diclofenac Sodium

---

## Products Affected

- *diclofenac sodium ophthalmic*

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

# Differin

---

## Products Affected

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

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

# Dificid

---

## Products Affected

- DIFICID

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

# Diffucan

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Bone marrow transplant - Candidiasis: Prophylaxis Candidal vulvovaginitis Candidiasis Cryptococcal meningitis Oropharyngeal candidiasis
<b>Exclusion Criteria</b>	Diffucan 150mg not included
<b>Required Medical Information</b>	A documented diagnosis of 1 of the below indications & specified criteria ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of generic fluconazole (if request is for brand Diffucan) Blastomycosis Bone Marrow Transplant (prophylaxis) Candidiasis (Systemic): Chronic cutaneous candidal infection Coccidoidmycosis or Coccidiomeningitis Chronic Candidal Paronychia Cryptococcus Cutaneous dermatophyte infection: NOTE: tinea pedis (athletes foot), tinea cruris (jock itch), or tinea corporis (ringworm on the body), does NOT include tinea versicolor ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 1 topical antifungal AND oral terbinafine Fungal Otitis externa ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 1 week of one preferred topical alternative Histoplasmosis HIV or Cancer Mastitis or a candidal infection of the breast (due to breast feeding/oral thrush in the infant) Tinea capitis ANDA documented contraindication/intolerance/allergy/failure of 2 weeks of generic terbinafine Tinea versicolor Urinary tract infection with Candida or Balanitis with Candida Vulvovaginal candidiasis (Vaginal Yeast Infection) Oral (thrush), esophageal, intestinal candidiasis Onychomycosis (Tinea unguium) due to dermatophyte ANDA documented positive lab test such as a KOH preparation, fungal culture, or nail biopsy (NOTE: This positive test should be within the last 3-6 months & associated with the current infection) ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of generic terbinafine OR any of the following: Presence of hepatic dysfunction or increased risk for liver disease Fungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection) ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of generic itraconazole
<b>Age Restrictions</b>	



PA Criteria	Criteria Details
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities of Diflucan, fluconazole, or Oravig for those members who meet ANY of the following criteria:</p> <p>For member that has a diagnosis of vulvovaginal candidiasis (VVC)/Vaginal Yeast Infection complicated with any of the following: antibiotic use or an immune compromised state such as HIV/AIDS or diabetes, or cancer, or chronic corticosteroid use: or recurrent (4 or more episodes per year) or severe VVC as determined by the physician ? for fluconazole/Diflucan (approval of 30 in 30 days for 1 year will be allowed)</p>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Diovan

---

## Products Affected

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

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

# Diovan HCT

## Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Diovan HCT

## Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dipentum

---

## Products Affected

- DIPENTUM

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

# Discount Drug Mart Test

---

## Products Affected

- *discount drug mart test*

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

# Ditropan XL

---

## Products Affected

- DITROPAN XL

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

# Dolophine

---

## Products Affected

- DOLOPHINE ORAL TABLET 5 MG

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



# Doryx

## Products Affected

- DORYX

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

# Doxycycline Hyclate

## Products Affected

- *doxycycline hyclate oral tablet delayed release*

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

# Doxycycline Monohydrate

## Products Affected

- *doxycycline monohydrate*

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

# Doxycycline Monohydrate

## Products Affected

- *doxycycline monohydrate*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acinetobacter infection Rosacea Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Documented to be 8 years of age or older (Note: see section above under ALL tetracyclines if less than 8 years of age) AND ONE of the following: A documented diagnosis of acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin) OR A documented diagnosis of infection other than acne or rosacea and a documented contraindication or intolerance or allergy or failure of an adequate trial of three days of the preferred generic alternative, doxycycline (for Adoxa or Monodox) or minocycline (for Dynacin or Minocin)
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	(If less than 8 years of age) A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)  (Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
<b>Notes/References</b>	

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

# Dronabinol

## Products Affected

- *dronabinol*

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

# Drospirenone-Ethinyl Estradiol

---

## Products Affected

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

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

# Drug Emporium Test

---

## Products Affected

- *drug emporium test*

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



# Duac

---

## Products Affected

- DUAC

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

# Duane Reade Test

---

## Products Affected

- *duane reade test*

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

# Duavee

---

## Products Affected

- DUAVEE

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

# Duetact

---

## Products Affected

- DUETACT

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

# Duexis

---

## Products Affected

- DUEXIS

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

# Dulera

---

## Products Affected

- DULERA

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

# DULoxetine HCl

---

## Products Affected

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

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

# DULoxetine HCl

---

## Products Affected

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

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



# DULoxetine HCl

---

## Products Affected

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

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

# Duo-Care Test

---

## Products Affected

- DUO-CARE TEST

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

# Duragesic-100

## Products Affected

- DURAGESIC-100

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	20 patch Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Duragesic-12

## Products Affected

- DURAGESIC-12

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	20 patch Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Duragesic-25

---

## Products Affected

- DURAGESIC-25

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	20 patch Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Duragesic-50

## Products Affected

- DURAGESIC-50

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	20 patch Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Duragesic-75

## Products Affected

- DURAGESIC-75

PA Criteria	Criteria Details
Covered Uses	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	20 patch Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Dutasteride

---

## Products Affected

- *dutasteride*

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



# Easy Plus Blood Glucose Test

---

## Products Affected

- *easy plus blood glucose test*

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

# Easy Plus II Glucose Test

---

## Products Affected

- *easy plus ii glucose test*

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

# Easy Step Test

---

## Products Affected

- EASY STEP TEST

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

# Easy Talk Blood Glucose Test

---

## Products Affected

- *easy talk blood glucose test*

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

# Easy Touch Test

---

## Products Affected

- EASY TOUCH TEST

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

# Easy Trak Blood Glucose Test

---

## Products Affected

- *easy trak blood glucose test*

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

# EasyGluco

---

## Products Affected

- EASYGLUCO IN VITRO

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

# EasyMax 15 Test

---

## Products Affected

- EASYMAX 15 TEST

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



# EASYMax Test

---

## Products Affected

- EASYMAX TEST

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

# EasyPlus Blood Glucose Test

---

## Products Affected

- *easyplus blood glucose test*

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

# EasyPRO Blood Glucose Test

---

## Products Affected

- EASYPRO BLOOD GLUCOSE TEST

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

# EasyPRO Plus

---

## Products Affected

- EASYPRO PLUS IN VITRO

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

# Eclipse Test

---

## Products Affected

- ECLIPSE TEST

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

# Edarbi

---

## Products Affected

- EDARBI

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

# Edarbyclor

---

## Products Affected

- EDARBYCLOR

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

# Edluar

---

## Products Affected

- EDLUAR

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



# Effexor XR

---

## Products Affected

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

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

# Effexor XR

---

## Products Affected

- EFFEXOR XR ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 150 MG

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

# Effient

## Products Affected

- EFFIENT

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acute coronary syndrome (ACS), which includes angina or myocardial infarction [MI]) managed by percutaneous coronary intervention (PCI)
<b>Exclusion Criteria</b>	History of Stroke or TIA
<b>Required Medical Information</b>	Member has a documented diagnosis of acute coronary syndrome (ACS), which includes angina or myocardial infarction [MI]) managed by percutaneous coronary intervention (PCI) AND Member has no prior history of stroke or transient ischemic attack (TIA)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Element Compact Test

---

## Products Affected

- *element compact test*

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

# Element Plus Test

---

## Products Affected

- ELEMENT PLUS TEST

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

# Element Test

---

## Products Affected

- ELEMENT TEST

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

# Elestrin

---

## Products Affected

- ELESTRIN

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

# Elidel

## Products Affected

- ELIDEL

PA Criteria	Criteria Details
<b>Covered Uses</b>	atopic dermatitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of mild to moderate atopic dermatitis in patients (eczema) less than 2 years of age for short-term use (up to 3 months) (Note: requirement of a trial of topical corticosteroid is not required)OR A documented diagnosis of atopic dermatitis (eczema) in an adult or child 2 years of age or older, AND one of the following:A documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient?s condition, ORA documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient?s condition, ORTreatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Face, genital area: 3 months, Other body areas: 6 months, Patients less than 2 yrs : 3 months
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Elinest

---

## Products Affected

- ELINEST

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

# Eliquis

---

## Products Affected

- ELIQUIS

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

# Ella

---

## Products Affected

- ELLA

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

# Elmiron

## Products Affected

- ELMIRON

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	interstitial cystitis.
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of interstitial cystitis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	
<b>QL Criteria</b>	3 caps Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Embeda

## Products Affected

- EMBEDA

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

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

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

# Embrace Blood Glucose Test

---

## Products Affected

- EMBRACE BLOOD GLUCOSE TEST

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

# Embrace Evo Blood Glucose Test

---

## Products Affected

- EMBRACE EVO BLOOD GLUCOSE TEST

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



# Embrace Pro Glucose Test

---

## Products Affected

- EMBRACE PRO GLUCOSE TEST

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

# Emend

---

## Products Affected

- EMEND ORAL CAPSULE 125 MG, 40 MG

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

# Emend

---

## Products Affected

- EMEND ORAL CAPSULE 80 MG

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

# Emend

---

## Products Affected

- EMEND ORAL CAPSULE 80 & 125 MG

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

# Emoquette

---

## Products Affected

- EMOQUETTE

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

# Emsam

---

## Products Affected

- EMSAM

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

# Enablex

---

## Products Affected

- ENABLEX

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

# Encare

---

## Products Affected

- ENCARE

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



# Enjuvia

---

## Products Affected

- ENJUVIA

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

# Enpresse-28

---

## Products Affected

- ENPRESSE-28

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

# Enskyce

---

## Products Affected

- ENSKYCE

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

# Entecavir

---

## Products Affected

- *entecavir*

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

# Entocort EC

---

## Products Affected

- ENTOCORT EC

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

# Entresto

## Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	Heart Failure
Exclusion Criteria	Known or suspected pregnancy
Required Medical Information	A documented diagnosis of chronic heart failure (NYHA Class II-IV) and reduced ejection fraction
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Envision Autocode Test

---

## Products Affected

- ENVISION AUTOCODE TEST

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

# Epaned

## Products Affected

- EPANED

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



# EQL TRUEtest Test

---

## Products Affected

- EQL TRUETEST TEST

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

# EQL TrueTrack Test

---

## Products Affected

- EQL TRUETRACK TEST

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

# Erivedge

---

## Products Affected

- ERIVEDGE

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

# Errin

---

## Products Affected

- ERRIN

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

# Esbriet

---

## Products Affected

- ESBRIET

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

# Escitalopram Oxalate

---

## Products Affected

- *escitalopram oxalate oral tablet*

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

# Escitalopram Oxalate

---

## Products Affected

- *escitalopram oxalate oral solution*

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

# Esomeprazole Magnesium

---

## Products Affected

- *esomeprazole magnesium*

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



# Esomeprazole Strontium

## Products Affected

- *esomeprazole strontium oral capsule delayed release 49.3 mg*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
<b>Exclusion Criteria</b>	(1) Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: (a) The heartburn can be controlled by use of OTC medications, and (b) There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis, and (c) There are no symptoms of a more complicated GI condition (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), OR (2) Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications, OR (3) Any of the following diagnoses when NOT in combination with a diagnosis listed above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: (a) Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal) and (b) Member is experiencing acid breakthrough, OR (c) Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. **NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.</p>

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

<b>ST Criteria</b>	Trial of ONEmonth each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium
<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Estarylla

---

## Products Affected

- ESTARYLLA

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

# Estradiol

---

## Products Affected

- *estradiol transdermal patch weekly*

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

# Estrasorb

---

## Products Affected

- ESTRASORB

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

# Estrogel

---

## Products Affected

- ESTROGEL

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

# Estrostep Fe

---

## Products Affected

- ESTROSTEP FE

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



# Eszopiclone

---

## Products Affected

- *eszopiclone*

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

# Evamist

---

## Products Affected

- EVAMIST

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

# Evekeo

## Products Affected

- EVEKEO

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

# EvenCare + Blood Glucose Test

---

## Products Affected

- EVENCARE + BLOOD GLUCOSE TEST

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

# EvenCare Blood Glucose Test

---

## Products Affected

- EVENCARE BLOOD GLUCOSE TEST

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

# EvenCare G2 Test

---

## Products Affected

- EVENCARE G2 TEST

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

# EvenCare G3 Test

---

## Products Affected

- EVENCARE G3 TEST

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

# Evolution Autocode

---

## Products Affected

- EVOLUTION AUTOCODE IN VITRO

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



# Evzio

## Products Affected

- EVZIO

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

# ExacTech R-S-G Test

---

## Products Affected

- EXACTECH R-S-G TEST

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

# ExacTech Test

---

## Products Affected

- EXACTECH TEST

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

# Exalgo

---

## Products Affected

- EXALGO ORAL 8 MG, 12 MG

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

# Exalgo

---

## Products Affected

- EXALGO ORAL 16 MG

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

# Exalgo

---

## Products Affected

- EXALGO ORAL 32 MG

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

# Exforge

---

## Products Affected

- EXFORGE

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

# Exforge HCT

---

## Products Affected

- EXFORGE HCT

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



# Express Med Test Strip Pack

---

## Products Affected

- *express med test strip pack*

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

# Ez Smart Blood Glucose Test

---

## Products Affected

- EZ SMART BLOOD GLUCOSE TEST

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

# Ez Smart Plus Glucose Test

---

## Products Affected

- EZ SMART PLUS GLUCOSE TEST

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

# Fabior

---

## Products Affected

- FABIOR

<b>ST Criteria</b>	Trial of one month each of two preferred alternatives indicated for the member's condition, one of which has to be tretinoin.
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Factive

## Products Affected

- FACTIVE

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

# Falmina

---

## Products Affected

- FALMINA

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

# Famciclovir

---

## Products Affected

- *famciclovir oral tablet 500 mg*

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

# Famciclovir

---

## Products Affected

- *famciclovir oral tablet 125 mg, 250 mg*

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



# Famvir

---

## Products Affected

- FAMVIR ORAL TABLET 500 MG

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

# Famvir

---

## Products Affected

- FAMVIR ORAL TABLET 125 MG, 250 MG

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

# Fanapt

---

## Products Affected

- FANAPT

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

# Fanapt Titration Pack

---

## Products Affected

- FANAPT TITRATION PACK

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

# Farxiga

---

## Products Affected

- FARXIGA

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

# Farydak

---

## Products Affected

- FARYDAK

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

# FastTake Test

---

## Products Affected

- FASTTAKE TEST

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

# FazaClo

---

## Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE  
12.5 MG

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



# FazaClo

---

## Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE  
200 MG

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

# FazaClo

---

## Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE  
100 MG

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

# FazaClo

---

## Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE  
150 MG

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

# FazaClo

---

## Products Affected

- FAZACLO ORAL TABLET DISPERSIBLE  
25 MG

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

# FC Female Condom

---

## Products Affected

- FC FEMALE CONDOM

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

# FC2 Female Condom

---

## Products Affected

- FC2 FEMALE CONDOM

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

# FemCap

---

## Products Affected

- FEMCAP

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

# Femhrt Low Dose

---

## Products Affected

- FEMHRT LOW DOSE

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



# Femring

---

## Products Affected

- FEMRING

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

# Fenoglide

---

## Products Affected

- FENOGLIDE

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

# FentaNYL

---

## Products Affected

- *fentanyl*

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

# FentaNYL

---

## Products Affected

- *fentanyl*

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

# FentaNYL Citrate

## Products Affected

- *fentanyl citrate buccal*

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

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

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

# Fentora

## Products Affected

- FENTORA

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

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

<b>ST Criteria</b>	A documented contraindication or intolerance or allergy or failure of an adequate trial of one week each of the preferred generic alternative, fentanyl transmucosal lozenge AND two other short acting opioids (i.e., morphine, hydrocodone, oxycodone, hydromorphone)
<b>QL Criteria</b>	15 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Fetzima

---

## Products Affected

- FETZIMA

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

# Fetzima Titration

---

## Products Affected

- FETZIMA TITRATION

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

# Fibricor

---

## Products Affected

- FIBRICOR

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

# Fifty50 Glucose Test 2.0

---

## Products Affected

- FIFTY50 GLUCOSE TEST 2.0

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

# Flector

---

## Products Affected

- FLECTOR

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

# Fluconazole

## Products Affected

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

PA Criteria	Criteria Details
<b>Covered Uses</b>	Bone marrow transplant - Candidiasis: Prophylaxis Candidal vulvovaginitis Candidiasis Cryptococcal meningitis Oropharyngeal candidiasis
<b>Exclusion Criteria</b>	Diflucan 150mg not included
<b>Required Medical Information</b>	A documented diagnosis of 1 of the below indications & specified criteria ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of generic fluconazole (if request is for brand Diflucan) Blastomycosis Bone Marrow Transplant (prophylaxis) Candidiasis (Systemic): Chronic cutaneous candidal infection Coccidoidmycosis or Coccidiomeningitis Chronic Candidal Paronychia Cryptococcus Cutaneous dermatophyte infection: NOTE: tinea pedis (athletes foot), tinea cruris (jock itch), or tinea corporis (ringworm on the body), does NOT include tinea versicolor ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 1 topical antifungal AND oral terbinafine Fungal Otitis externa ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 1 week of one preferred topical alternative Histoplasmosis HIV or Cancer Mastitis or a candidal infection of the breast (due to breast feeding/oral thrush in the infant) Tinea capitis ANDA documented contraindication/intolerance/allergy/failure of 2 weeks of generic terbinafine Tinea versicolor Urinary tract infection with Candida or Balanitis with Candida Vulvovaginal candidiasis (Vaginal Yeast Infection) Oral (thrush), esophageal, intestinal candidiasis Onychomycosis (Tinea unguium) due to dermatophyte ANDA documented positive lab test such as a KOH preparation, fungal culture, or nail biopsy (NOTE: This positive test should be within the last 3-6 months & associated with the current infection) ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of generic terbinafine OR any of the following: Presence of hepatic dysfunction or increased risk for liver disease Fungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection) ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of generic itraconazole
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	

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

PA Criteria	Criteria Details
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. A prior authorization will be granted for coverage of additional quantities of Diflucan, fluconazole, or Oravig for those members who meet ANY of the following criteria:</p> <p>For member that has a diagnosis of vulvovaginal candidiasis (VVC)/Vaginal Yeast Infection complicated with any of the following: antibiotic use or an immune compromised state such as HIV/AIDS or diabetes, or cancer, or chronic corticosteroid use: or recurrent (4 or more episodes per year) or severe VVC as determined by the physician ? for fluconazole/Diflucan (approval of 30 in 30 days for 1 year will be allowed)</p>
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# FLUoxetine HCl

---

## Products Affected

- *fluoxetine hcl oral capsule 40 mg*

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



# FLUoxetine HCl

---

## Products Affected

- *fluoxetine hcl oral capsule delayed release*

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

# FLUoxetine HCl

---

## Products Affected

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

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

# FLUoxetine HCl

---

## Products Affected

- *fluoxetine hcl oral solution*

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

# FLUoxetine HCl

---

## Products Affected

- *fluoxetine hcl oral capsule 10 mg*

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

# FLUoxetine HCl

---

## Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

# FLUoxetine HCl

---

## Products Affected

- *fluoxetine hcl oral capsule 20 mg*

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

# Flurbiprofen Sodium

---

## Products Affected

- *flurbiprofen sodium*

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

# Fluvastatin Sodium

---

## Products Affected

- *fluvastatin sodium*

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



# Fluvastatin Sodium ER

---

## Products Affected

- *fluvastatin sodium er*

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

# FluvoxaMINE Maleate

---

## Products Affected

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

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

# FluvoxaMINE Maleate

---

## Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

# FluvoxaMINE Maleate ER

---

## Products Affected

- *fluvoxamine maleate er*

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

# Focalin

## Products Affected

- FOCALIN

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

# Focalin XR

## Products Affected

- FOCALIN XR

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

# FORA D10 Blood Glucose Test

---

## Products Affected

- FORA D10 BLOOD GLUCOSE TEST

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

# FORA D15C Blood Glucose Test

---

## Products Affected

- FORA D15C BLOOD GLUCOSE TEST

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



# FORA D15g Blood Glucose Test

---

## Products Affected

- FORA D15G BLOOD GLUCOSE TEST

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

# FORA D15z Blood Glucose Test

---

## Products Affected

- FORA D15Z BLOOD GLUCOSE TEST

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

# FORA D20 Blood Glucose Test

---

## Products Affected

- FORA D20 BLOOD GLUCOSE TEST

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

# FORA G20 Blood Glucose Test

---

## Products Affected

- FORA G20 BLOOD GLUCOSE TEST

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

# FORA G30a Blood Glucose Test

---

## Products Affected

- FORA G30A BLOOD GLUCOSE TEST

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

# FORA G71a Blood Glucose Test

---

## Products Affected

- FORA G71A BLOOD GLUCOSE TEST

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

# FORA G90 Blood Glucose Test

---

## Products Affected

- FORA G90 BLOOD GLUCOSE TEST

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

# Fora GD20 Test

---

## Products Affected

- FORA GD20 TEST

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



# FORA V10 Blood Glucose Test

---

## Products Affected

- FORA V10 BLOOD GLUCOSE TEST

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

# FORA V12 Blood Glucose Test

---

## Products Affected

- FORA V12 BLOOD GLUCOSE TEST

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

# FORA V20 Blood Glucose Test

---

## Products Affected

- FORA V20 BLOOD GLUCOSE TEST

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

# FORA V22 Blood Glucose Test

---

## Products Affected

- FORA V22 BLOOD GLUCOSE TEST

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

# FORA V30a Blood Glucose Test

---

## Products Affected

- FORA V30A BLOOD GLUCOSE TEST

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

# ForaCare GD40 Test

---

## Products Affected

- FORACARE GD40 TEST

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

# ForaCare premium V10 Test

---

## Products Affected

- FORACARE PREMIUM V10 TEST

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

# ForaCare Test N Go Test

---

## Products Affected

- FORACARE TEST N GO TEST

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



# Foradil Aerolizer

---

## Products Affected

- FORADIL AEROLIZER

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

# Forfivo XL

---

## Products Affected

- FORFIVO XL

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

# Fortesta

## Products Affected

- FORTESTA

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	4 pumps Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Fosamax

---

## Products Affected

- FOSAMAX

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

# Fosamax Plus D

---

## Products Affected

- FOSAMAX PLUS D

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

# Fragmin

---

## Products Affected

- FRAGMIN SUBCUTANEOUS\* SOLUTION  
95000 UNIT/3.8ML

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

# FreeStyle InsuLinx Test

---

## Products Affected

- FREESTYLE INSULINX TEST

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

# FreeStyle Lite Test

---

## Products Affected

- FREESTYLE LITE TEST

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



# FreeStyle Test

---

## Products Affected

- FREESTYLE TEST

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

# Frova

---

## Products Affected

- FROVA

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

# Fulyzaq

---

## Products Affected

- FULYZAQ

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

# Fycompa

---

## Products Affected

- FYCOMPA

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

# Gabapentin

---

## Products Affected

- *gabapentin oral solution*

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

# Gabapentin

---

## Products Affected

- *gabapentin oral capsule*

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

# Gabapentin

---

## Products Affected

- *gabapentin oral tablet*

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

# Gabril

---

## Products Affected

- GABITRIL ORAL TABLET 16 MG

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



# Gabril

---

## Products Affected

- GABITRIL ORAL TABLET 12 MG, 4 MG

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

# Gabril

---

## Products Affected

- GABITRIL ORAL TABLET 2 MG

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

# Garamycin

---

## Products Affected

- GARAMYCIN OPHTHALMIC SOLUTION

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

# Gatifloxacin

---

## Products Affected

- *gatifloxacin*

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

# GE100 Blood Glucose Test

---

## Products Affected

- *ge100 blood glucose test*

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

# Gelnique

---

## Products Affected

- GELNIQUE

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

# Gentamicin Sulfate

---

## Products Affected

- *gentamicin sulfate ophthalmic solution*

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

# Geodon

---

## Products Affected

- GEODON ORAL

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



# Giant Eagle Pharm Test

---

## Products Affected

- *giant eagle pharm test*

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

# Gianvi

---

## Products Affected

- GIANVI

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

# Giazo

---

## Products Affected

- GIAZO

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

# Gildagia

---

## Products Affected

- GILDAGIA

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

# Gildess 1.5/30

---

## Products Affected

- GILDESS 1.5/30

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

# Gildess 1/20

---

## Products Affected

- GILDESS 1/20

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

## Gildess FE 1.5/30

---

### Products Affected

- GILDESS FE 1.5/30

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

# Gildess FE 1/20

---

## Products Affected

- GILDESS FE 1/20

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



# Gilenya

---

## Products Affected

- GILENYA

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

# Gilotrif

---

## Products Affected

- GILOTRIF

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

# Gleevec

---

## Products Affected

- GLEEVEC

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

# Gluco Perfect 3 Test

---

## Products Affected

- GLUCO PERFECT 3 TEST

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

# Glucocard 01 Sensor Plus

---

## Products Affected

- GLUCOCARD 01 SENSOR PLUS

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

# Glucocard Expression Test

---

## Products Affected

- GLUCOCARD EXPRESSION TEST

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

# Glucocard Shine Test

---

## Products Affected

- GLUCOCARD SHINE TEST

<b>QL Criteria</b>	300 strips Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Glucocard Vital Test

---

## Products Affected

- GLUCOCARD VITAL TEST

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



# Glucocard X-Sensor

---

## Products Affected

- GLUCOCARD X-SENSOR

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

# GlucoCom Test

---

## Products Affected

- GLUCOCOM TEST

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

# Glucolab Test

---

## Products Affected

- GLUCOLAB TEST

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

# GlucoNavii Blood Glucose Test

---

## Products Affected

- GLUCONAVII BLOOD GLUCOSE TEST

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

# Glycate

---

## Products Affected

- GLYCATE

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

# Glyxambi

---

## Products Affected

- GLYXAMBI

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

# Gmate Blood Glucose Test

---

## Products Affected

- GMATE BLOOD GLUCOSE TEST

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

# Gralise

---

## Products Affected

- GRALISE ORAL TABLET 600 MG

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



# Gralise

---

## Products Affected

- GRALISE ORAL TABLET 300 MG

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

# Gralise Starter

---

## Products Affected

- GRALISE STARTER

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

# Granisetron HCl

---

## Products Affected

- *granisetron hcl oral*

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

# Granisol

---

## Products Affected

- GRANISOL

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

# GuanFACINE HCl ER

---

## Products Affected

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

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

# Harvoni

---

## Products Affected

- HARVONI

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

# Health Alliance

---

## Products Affected

- HEALTH ALLIANCE

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

# Heather

---

## Products Affected

- HEATHER

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



# Hycamtin

---

## Products Affected

- HYCAMTIN ORAL

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

# Hydroxychloroquine Sulfate

---

## Products Affected

- *hydroxychloroquine sulfate oral*

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

# Hysingla ER

## Products Affected

- HYSINGLA ER

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

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

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

# Hyzaar

## Products Affected

- HYZAAR ORAL TABLET 50-12.5 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
QL Criteria	1 tab Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Hyzaar

## Products Affected

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

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/ References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ibandronate Sodium

---

## Products Affected

- *ibandronate sodium oral*

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

# Ibrance

---

## Products Affected

- IBRANCE

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



# Iclusig

---

## Products Affected

- ICLUSIG

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

# Ilevro

---

## Products Affected

- ILEVRO

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

# Imbruvica

---

## Products Affected

- IMBRUVICA

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

# Imiquimod

---

## Products Affected

- *imiquimod external*

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

# Imitrex

---

## Products Affected

- IMITREX SUBCUTANEOUS\*

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

# Imitrex

---

## Products Affected

- IMITREX NASAL

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

# Imitrex

---

## Products Affected

- IMITREX ORAL

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

# Implanon

---

## Products Affected

- IMPLANON

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



# Incruse Ellipta

---

## Products Affected

- INCRUSE ELLIPTA

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

# Infinity Blood Glucose Test

---

## Products Affected

- INFINITY BLOOD GLUCOSE TEST

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

# Inlyta

---

## Products Affected

- INLYTA

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

# Intermezzo

---

## Products Affected

- INTERMEZZO SUBLINGUAL TABLET  
SUBLINGUAL 1.75 MG

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

# Intermezzo

## Products Affected

- INTERMEZZO SUBLINGUAL TABLET  
SUBLINGUAL 3.5 MG

PA Criteria	Criteria Details
Covered Uses	Insomnia
Exclusion Criteria	
Required Medical Information	For Intermezzo 1.75 mg - (for males or females)A documented diagnosis of treatment of insomnia when middle-of-the-night awakening is followed by difficulty returning to sleepFor Intermezzo 3.5mg ? (for males only)A documented diagnosis of treatment of insomnia when middle of the night awakening is followed by difficulty returning to sleep AND ALL of the following:Member is maleMember is less than or equal to 65 years of oldIt is documented they will NOT be taking Intermezzo concomitantly with other CNS depressants (e.g. benzodiazepines, opioids, tricyclic antidepressants, alcohol)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 7 days (one week) of the preferred generic alternative zolpidem OR zolpidem er.
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Introvale

---

## Products Affected

- INTROVALE

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

# Intuniv

## Products Affected

- INTUNIV

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Diagnosis required for 18 and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: Only members 18 and over are subject to diagnosis criteria.
ST Criteria	Trial of 14 days each of 3 of: clonidine/ sr, guanfacine, amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera OR Vyvanse
QL Criteria	1 tablet Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Invega

---

## Products Affected

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

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



# Invega

---

## Products Affected

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

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

# Invokamet

---

## Products Affected

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

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

# Invokamet

---

## Products Affected

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

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

# Invokana

---

## Products Affected

- INVOKANA

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

# Irbesartan

---

## Products Affected

- *irbesartan oral tablet 75 mg, 150 mg*

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

# Irbesartan-Hydrochlorothiazide

---

## Products Affected

- irbesartan-hydrochlorothiazide oral tablet*  
150-12.5 mg

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

# Irenka

---

## Products Affected

- IRENKA

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

# Iressa

---

## Products Affected

- IRESSA

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



# Itraconazole

## Products Affected

- *itraconazole oral*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Aspergillosis, Invasive, salvage therapy Blastomycosis Candidiasis of the esophagus Histoplasmosis, Disseminated Onychomycosis due to dermatophyte Oropharyngeal candidiasis Pulmonary histoplasmosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the below indications and specified criteria AND A documented contraindication/intolerance/allergy/failure of an adequate trial of generic itraconazole (if request is for brand Sporanox)AspergillosisBlastomycosisTreatment of oropharyngeal/esophageal candidiasis in HIV-infected personsChromoblastomycosisCoccidioidomycosis associated with AIDS, treatment and prophylaxisCryptococcosisCryptococcal meningitis - HIV infectionCutaneous dermatophyte infection: NOTE: tinea pedis/manuum (athletes foot/hand), tinea cruris (jock itch), or tinea corporis (ringworm on the body), does NOT include tinea versicolor] ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of one topical antifungal AND preferred generic oral terbinafineFebrile neutropeniaHistoplasmosisPenicillium marneffeii infectionProphylaxis of invasive fungal infections in persons with Chronic Granulomatous Disease, hematologic malignancies or liver transplantsDisseminated microsporidiosis caused by Trachipleistophora or Brachiola species in HIV-infected personsOnychomycosis (Tinea unguium) due to dermatophyte ANDA documented positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis of onychomycosis (NOTE: This positive test should be recent (within the last 3-6 months) and associated with the current infection)AND A documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of preferred generic terbinafine OR any of the following:Presence of hepatic dysfunction or increased risk for liver diseaseFungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection)ParacoccidioidomycosisSporotrichosisTinea versicolorTinea capitis AND A documented contraindication/intolerance/allergy/failure of two weeks of generic terbinafineVulvovaginal Candidiasis
<b>Age Restrictions</b>	

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

# Jakafi

---

## Products Affected

- JAKAFI

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

# Jalyn

## Products Affected

- JALYN

PA Criteria	Criteria Details
Covered Uses	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	For coverage in females members:Member is NOT pregnantANDMember?s physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Janumet

---

## Products Affected

- JANUMET

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

# Janumet XR

---

## Products Affected

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

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

# Janumet XR

---

## Products Affected

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

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

# Januvia

---

## Products Affected

- JANUVIA

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



# Jardiance

---

## Products Affected

- JARDIANCE

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

# Jencycla

---

## Products Affected

- JENCYCLA

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

# Jentaduetto

---

## Products Affected

- JENTADUETO

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

# Jolessa

---

## Products Affected

- JOLESSA

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

# Jolivette

---

## Products Affected

- JOLIVETTE

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

# Jublia

## Products Affected

- JUBLIA

PA Criteria	Criteria Details
Covered Uses	Onychomycosis due to dermatophyte
Exclusion Criteria	
Required Medical Information	(1) A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (positive test should be recent (within the last 3 - 6 months) and associated with the current infection) and, (2) a documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative either terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), fluconazole (6 months), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail) OR presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis) OR member is female and is pregnant and/or breastfeeding, and (3) Member is NOT receiving a systemic (oral) antifungal agent - terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step therapy applies
Notes/References	
Revision Date	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Junel 1.5/30

---

## Products Affected

- JUNEL 1.5/30

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

# Junel 1/20

---

## Products Affected

- JUNEL 1/20

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



# Junel FE 1.5/30

---

## Products Affected

- JUNEL FE 1.5/30

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

# Junel FE 1/20

---

## Products Affected

- JUNEL FE 1/20

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

# Juxtapid

---

## Products Affected

- JUXTAPID ORAL CAPSULE 20 MG

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

# Juxtapid

---

## Products Affected

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

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

# Juxtapid

---

## Products Affected

- JUXTAPID ORAL CAPSULE 5 MG

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

# Juxtapid

---

## Products Affected

- JUXTAPID ORAL CAPSULE 10 MG

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

# Kadian

## Products Affected

- KADIAN

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

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



# Kalydeco

---

## Products Affected

- KALYDECO

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

# Kalydeco

---

## Products Affected

- KALYDECO

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

# Kapvay

## Products Affected

- KAPVAY ORAL TABLET EXTENDED RELEASE 12 HR\*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Attention deficit hyperactivity disorder (ADHD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	
<b>Age Restrictions</b>	Diagnosis required for 18 and older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Note: Only members 18 and over are subject to diagnosis criteria.
<b>ST Criteria</b>	Trial of 14 days each of 3 of: clonidine/ sr, guanfacine, amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera OR Vyvanse
<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Kariva

---

## Products Affected

- KARIVA

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

# Kazano

---

## Products Affected

- KAZANO

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

# Kelnor 1/35

---

## Products Affected

- KELNOR 1/35

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

# Keppra XR

---

## Products Affected

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

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

# Keppra XR

---

## Products Affected

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

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



# Kerr Drug Test Strip Pack

---

## Products Affected

- *kerr drug test strip pack*

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

# Ketorolac Tromethamine

---

## Products Affected

- *ketorolac tromethamine ophthalmic*

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

# Ketorolac Tromethamine

---

## Products Affected

- *ketorolac tromethamine oral*

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

# Keveyis

---

## Products Affected

- KEVEYIS

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

# Khedeza

---

## Products Affected

- KHEDEZLA

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

# Kinray Test

---

## Products Affected

- *kinray test*

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

# Kombiglyze XR

---

## Products Affected

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

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

# Kombiglyze XR

---

## Products Affected

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

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



# Korlym

---

## Products Affected

- KORLYM

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

# Kroger Blood Glucose Test

---

## Products Affected

- *kroger blood glucose test*

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

# Kroger Premium Glucose Test

---

## Products Affected

- *kroger premium glucose test*

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

# Kroger Test

---

## Products Affected

- *kroger test*

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

# Kurvelo

---

## Products Affected

- KURVELO

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

# LaMICtal ODT

---

## Products Affected

- LAMICTAL ODT ORAL TABLET  
DISPERSIBLE 200 MG, 100 MG

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

# LaMICtal ODT

---

## Products Affected

- LAMICTAL ODT ORAL TABLET  
DISPERSIBLE 50 MG

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

# LaMICtal ODT

---

## Products Affected

- LAMICTAL ODT ORAL TABLET  
DISPERSIBLE 25 MG

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



# LaMICtal XR

---

## Products Affected

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

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

# LaMICtal XR

---

## Products Affected

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

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

# LaMICtal XR

---

## Products Affected

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

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

# LamoTRIGine

---

## Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

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

# LamoTRigine

---

## Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

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

# LamoTRIGine

---

## Products Affected

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

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

# LamoTRIGine ER

---

## Products Affected

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

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

# LamoTRIGine ER

---

## Products Affected

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

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



# LamoTRIGine ER

---

## Products Affected

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

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

# Lansoprazole

---

## Products Affected

- *lansoprazole oral capsule delayed release 30 mg*

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

# Larin 1/20

---

## Products Affected

- LARIN 1/20

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

# Larin Fe 1.5/30

---

## Products Affected

- LARIN FE 1.5/30

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

# Larin Fe 1/20

---

## Products Affected

- LARIN FE 1/20

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

# Latanoprost

---

## Products Affected

- *latanoprost ophthalmic*

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

# Latuda

---

## Products Affected

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

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

# Latuda

---

## Products Affected

- LATUDA ORAL TABLET 80 MG

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



# Lazanda

## Products Affected

- LAZANDA

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

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

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

# Leena

---

## Products Affected

- LEENA

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

# Leflunomide

## Products Affected

- *leflunomide oral*

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

# Lemtrada

---

## Products Affected

- LEMTRADA

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

# Lenvima 10 MG Daily Dose

---

## Products Affected

- LENVIMA 10 MG DAILY DOSE

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

# Lenvima 14 MG Daily Dose

---

## Products Affected

- LENVIMA 14 MG DAILY DOSE

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

# Lenvima 20 MG Daily Dose

---

## Products Affected

- LENVIMA 20 MG DAILY DOSE

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



# Lenvima 24 MG Daily Dose

---

## Products Affected

- LENVIMA 24 MG DAILY DOSE

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

# Lescol

---

## Products Affected

- LESCOLO

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

# Lescol XL

---

## Products Affected

- LESCOL XL

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

# Lessina

---

## Products Affected

- LESSINA

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

# Levaquin

## Products Affected

- LEVAQUIN ORAL

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

# LevETIRAcetam ER

---

## Products Affected

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

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

# LevETIRAcetam ER

---

## Products Affected

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

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

# Levocetirizine Dihydrochloride

## Products Affected

- *levocetirizine dihydrochloride oral tablet*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than $\geq$ 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	



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

# Levocetirizine Dihydrochloride

## Products Affected

- *levocetirizine dihydrochloride oral solution*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than $\geq$ 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
<b>QL Criteria</b>	10 ml Per 1 Day
<b>Notes/References</b>	

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

# Levofloxacin

## Products Affected

- *levofloxacin oral*

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

# Levonest

---

## Products Affected

- LEVONEST

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

# Levonorgest-Eth Estrad 91-Day

---

## Products Affected

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

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

# Levonorgestrel

---

## Products Affected

- *levonorgestrel oral tablet 0.75 mg*

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

# Levonorgestrel-Ethinyl Estrad

---

## Products Affected

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

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



# Levonorgestrel-Ethinyl Estrad

---

## Products Affected

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

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

## Levora 0.15/30 (28)

---

### Products Affected

- LEVORA 0.15/30 (28)

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

# Lexapro

---

## Products Affected

- LEXAPRO ORAL SOLUTION

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

# Lexapro

---

## Products Affected

- LEXAPRO ORAL TABLET

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

# Lialda

---

## Products Affected

- LIALDA

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

# Liberty Next Generation Test

---

## Products Affected

- LIBERTY NEXT GENERATION TEST

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

# Liberty Test

---

## Products Affected

- *liberty test*

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

# Lidoderm

## Products Affected

- LIDODERM

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



# Life Medical Test

---

## Products Affected

- *life medical test*

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

# Linzezz

---

## Products Affected

- LINZEZZ

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

# Lipitor

---

## Products Affected

- LIPITOR

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

# Lipofen

---

## Products Affected

- LIPOFEN

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

# Liptruzet

---

## Products Affected

- LIPTRUZET

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

# Livalo

---

## Products Affected

- LIVALO

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

# Locoid

---

## Products Affected

- LOCOID

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

# Locoid Lipocream

---

## Products Affected

- LOCOID LIPOCREAM

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



# Lofibra

---

## Products Affected

- LOFIBRA

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

# Long Test

---

## Products Affected

- *long test*

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

# Lonsurf

---

## Products Affected

- LONSURF ORAL TABLET 15-6.14 MG

<b>QL Criteria</b>	100 tablets Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 10, 2015

# Lonsurf

---

## Products Affected

- LONSURF ORAL TABLET 20-8.19 MG

<b>QL Criteria</b>	80 tablets Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 10, 2015

# Lopid

---

## Products Affected

- LOPID

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

# Loryna

---

## Products Affected

- LORYNA

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

# Losartan Potassium

---

## Products Affected

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

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

# Losartan Potassium-HCTZ

---

## Products Affected

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

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



# LoSeasonique

---

## Products Affected

- LOSEASONIQUE

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

# Lotrel

---

## Products Affected

- LOTREL

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

# Lotronex

## Products Affected

- LOTRONEX

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

# Lovastatin

---

## Products Affected

- *lovastatin*

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

# Lovaza

---

## Products Affected

- LOVAZA

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

# Low-Ogestrel

---

## Products Affected

- LOW-OGESTREL

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

# Lumigan

---

## Products Affected

- LUMIGAN OPHTHALMIC SOLUTION 0.01  
%

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

# Lunesta

---

## Products Affected

- LUNESTA

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



# Lutera

---

## Products Affected

- LUTERA

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

# Luvox CR

---

## Products Affected

- LUVOX CR

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

# Luxiq

---

## Products Affected

- LUXIQ

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

# Lynparza

---

## Products Affected

- LYNPARZA

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

# Lysteda

---

## Products Affected

- LYSTEDA

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

# Lyza

---

## Products Affected

- LYZA

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

# Makena

---

## Products Affected

- MAKENA

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

# Malarone

## Products Affected

- MALARONE

PA Criteria	Criteria Details
<b>Covered Uses</b>	Malaria
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of malaria
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Malaria: 30 days Other Diagnosis: 1 year
<b>Other Criteria</b>	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Marinol

## Products Affected

- MARINOL

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

# Marlissa

---

## Products Affected

- *marlissa*

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

# Maxalt

---

## Products Affected

- MAXALT

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

# Maxalt-MLT

---

## Products Affected

- MAXALT-MLT

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

# Maxima Blood Glucose Test

---

## Products Affected

- MAXIMA BLOOD GLUCOSE TEST

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

# Maxitrol

---

## Products Affected

- MAXITROL OPHTHALMIC SUSPENSION

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

# MedroxyPROGESTERone Acetate

---

## Products Affected

- *medroxyprogesterone acetate intramuscular\**

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

# Mefloquine HCl

## Products Affected

- *mefloquine hcl*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Malaria
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of malaria
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Malaria: 30 days Other Diagnosis: 1 year
<b>Other Criteria</b>	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of this drug will be considered medically necessary for those members who meet ANY of the following criteria: Diagnosis of uncomplicated Plasmodium falciparum malaria necessitating one additional treatment- may approve an additional 42 capsules one time
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Meijer Blood Glucose Test

---

## Products Affected

- *meijer blood glucose test*

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

# Meijer Premium Glucose Test

---

## Products Affected

- *meijer premium glucose test*

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

# Meijer Test

---

## Products Affected

- *meijer test*

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

# Meijer TRUEtest Test

---

## Products Affected

- MEIJER TRUETEST TEST

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

# Meijer TRUEtrack Test

---

## Products Affected

- MEIJER TRUETRACK TEST

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

# Mekinist

---

## Products Affected

- MEKINIST

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

# Menostar

---

## Products Affected

- MENOSTAR

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

# Metadate CD

## Products Affected

- METADATE CD

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



# Metadate ER

---

## Products Affected

- METADATE ER

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

# Methadone HCl

---

## Products Affected

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

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

# Methadose

---

## Products Affected

- METHADOSE ORAL TABLET SOLUBLE
- METHADOSE ORAL TABLET

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

# Methamphetamine HCl

---

## Products Affected

- *methamphetamine hcl*

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

# Methylin

## Products Affected

- METHYLIN ORAL SOLUTION 10 MG/5ML

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

# Methylin

## Products Affected

- METHYLIN ORAL SOLUTION 5 MG/5ML

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

# Methylin

## Products Affected

- METHYLIN ORAL TABLET CHEWABLE

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

# Methylphenidate HCl

---

## Products Affected

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

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



# Methylphenidate HCl

---

## Products Affected

- *methylphenidate hcl oral tablet*

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

# Methylphenidate HCl

---

## Products Affected

- *methylphenidate hcl oral tablet chewable*

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

# Methylphenidate HCl

---

## Products Affected

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

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

# Methylphenidate HCl ER

---

## Products Affected

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

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

# Methylphenidate HCl ER

---

## Products Affected

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

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

# Methylphenidate HCl ER

---

## Products Affected

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

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

# Methylphenidate HCl ER (CD)

---

## Products Affected

- *methylphenidate hcl er (cd)*

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

# Methylphenidate HCl ER (LA)

---

## Products Affected

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

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



# Methylphenidate HCl ER (LA)

---

## Products Affected

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

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

# Mevacor

---

## Products Affected

- MEVACOR

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

# Miacalcin

---

## Products Affected

- MIACALCIN NASAL

<b>QL Criteria</b>	0.12 ML Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Microdot Test

---

## Products Affected

- MICRODOT TEST

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

# Microgestin 1.5/30

---

## Products Affected

- MICROGESTIN 1.5/30

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

# Microgestin 1/20

---

## Products Affected

- MICROGESTIN 1/20

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

# Microgestin FE 1.5/30

---

## Products Affected

- MICROGESTIN FE 1.5/30

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

# Microgestin FE 1/20

---

## Products Affected

- MICROGESTIN FE 1/20

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



# Migranal

---

## Products Affected

- MIGRANAL

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

# Mimvey

---

## Products Affected

- MIMVEY

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

# Minivelle

---

## Products Affected

- MINIVELLE TRANSDERMAL PATCH  
BIWEEKLY 0.075 MG/24HR, 0.05  
MG/24HR, 0.0375 MG/24HR, 0.1 MG/24HR

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

# Minivelle

---

## Products Affected

- MINIVELLE TRANSDERMAL PATCH  
BIWEEKLY 0.025 MG/24HR

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

# Minocycline HCl ER

## Products Affected

- *minocycline hcl er*

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

# Mirapex ER

---

## Products Affected

- MIRAPEX ER

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

# Mirena

---

## Products Affected

- MIRENA

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

# Mirtazapine

---

## Products Affected

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

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



# Mirvaso

---

## Products Affected

- MIRVASO

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

# Mitigare

---

## Products Affected

- MITIGARE

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

# Modafinil

## Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
Exclusion Criteria	
Required Medical Information	Narcolepsy, confirmed by sleep lab evaluation OROSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following:Member is currently using an oral/dental applianceMember has undergone an uvulopalatopharyngoplasty (UPPP)Member is greater than or equal to 65 yrs of ageMember has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following:Member is compliant with and currently using CPAP/BiPAP treatmentMember is experiencing excessive sleepiness despite CPAP/BiPAP use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Mono-Linyah

---

## Products Affected

- MONO-LINYAH

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

# MonoNessa

---

## Products Affected

- MONONESSA

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

# Montelukast Sodium

---

## Products Affected

- *montelukast sodium oral*

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

# Montelukast Sodium

---

## Products Affected

- *montelukast sodium oral*

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

# Movantik

## Products Affected

- MOVANTIK

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



# Moxeza

---

## Products Affected

- MOXEZA

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

# MS Contin

---

## Products Affected

- MS CONTIN

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

# MyGlucoHealth Test

---

## Products Affected

- MYGLUCOHEALTH TEST

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

# Myorisan

## Products Affected

- MYORISAN ORAL CAPSULE 10 MG, 20 MG, 40 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria: 1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Myzilra

---

## Products Affected

- MYZILRA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Naratriptan HCl

---

## Products Affected

- *naratriptan hcl*

<b>QL Criteria</b>	9 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Natacyn

---

## Products Affected

- NATACYN

<b>QL Criteria</b>	1 pen Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Natesto

## Products Affected

- NATESTO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	3 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

2015 Aetna Pharmacy Plan Drug List - Premier  
 (Updated 12/01/15)



# Natpara

---

## Products Affected

- NATPARA

<b>QL Criteria</b>	2 cartridges Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Navarro Blood Glucose Test

---

## Products Affected

- NAVARRO BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Necon 0.5/35 (28)

---

## Products Affected

- NECON 0.5/35 (28)

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Necon 1/35 (28)

---

## Products Affected

- NECON 1/35 (28)

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Necon 10/11 (28)

---

### Products Affected

- NECON 10/11 (28)

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Necon 7/7/7

---

## Products Affected

- NECON 7/7/7

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neomycin-Polymyxin-Dexameth

---

## Products Affected

- *neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1*

<b>QL Criteria</b>	15 pen Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neomycin-Polymyxin-Gramicidin

---

## Products Affected

- *neomycin-polymyxin-gramicidin*

<b>QL Criteria</b>	1 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Neomycin-Polymyxin-HC

---

## Products Affected

- *neomycin-polymyxin-hc otic solution*  
3.5-10000-1

<b>QL Criteria</b>	2 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neomycin-Polymyxin-HC

---

## Products Affected

- *neomycin-polymyxin-hc otic suspension*

<b>QL Criteria</b>	2 pen Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neosporin

---

## Products Affected

- NEOSPORIN

<b>QL Criteria</b>	1 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nesina

---

## Products Affected

- NESINA

<b>ST Criteria</b>	Trial of one month each of two preferred brand products (Januvia, Onglyza, Tradjenta).
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neupro

---

## Products Affected

- NEUPRO

<b>QL Criteria</b>	1 patch Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neurontin

---

## Products Affected

- NEURONTIN ORAL CAPSULE

<b>QL Criteria</b>	6 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neurontin

---

## Products Affected

- NEURONTIN ORAL TABLET

<b>QL Criteria</b>	6 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Neutek 2Tek Test

---

## Products Affected

- NEUTEK 2TEK TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Nevanac

---

## Products Affected

- NEVANAC

<b>QL Criteria</b>	15 pen Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NexAVAR

---

## Products Affected

- NEXAVAR

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NexGen Test

---

## Products Affected

- NEXGEN TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NexIUM

---

## Products Affected

- NEXIUM

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NexIUM

---

## Products Affected

- NEXIUM

<b>QL Criteria</b>	1 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nexplanon

---

## Products Affected

- NEXPLANON

<b>QL Criteria</b>	1 pack Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nicoderm CQ

---

## Products Affected

- NICODERM CQ

<b>QL Criteria</b>	1 patch Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nicorette

---

## Products Affected

- NICORETTE MOUTH/THROAT GUM

<b>QL Criteria</b>	24 pieces Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Nicorette

---

## Products Affected

- NICORETTE MOUTH/THROAT LOZENGE

<b>QL Criteria</b>	20 pieces Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nicorette Mini

---

## Products Affected

- NICORETTE MINI

<b>QL Criteria</b>	20 pieces Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nicotine

---

## Products Affected

- *nicotine*

<b>QL Criteria</b>	1 patch Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nicotine Polacrilex

---

## Products Affected

- *nicotine polacrilex mouth/throat lozenge*

<b>QL Criteria</b>	20 pieces Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nicotine Polacrilex

---

## Products Affected

- *nicotine polacrilex mouth/throat gum*

<b>QL Criteria</b>	24 pieces Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nicotrol

---

## Products Affected

- NICOTROL

<b>QL Criteria</b>	16 cartridges Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nicotrol NS

---

## Products Affected

- NICOTROL NS

<b>QL Criteria</b>	12 bottles Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nora-BE

---

## Products Affected

- NORA-BE

<b>QL Criteria</b>	1.5 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Norethindrone

---

## Products Affected

- *norethindrone oral*

<b>QL Criteria</b>	1.5 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Norethindrone-Eth Estradiol

---

## Products Affected

- *norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg*

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Norgestimate-Eth Estradiol

---

## Products Affected

- *norgestimate-eth estradiol*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Norgestim-Eth Estrad Triphasic

---

## Products Affected

- *norgestim-eth estrad triphasic*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Norgestrel-Ethinyl Estradiol

---

## Products Affected

- *norgestrel-ethinyl estradiol*

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Noroxin

## Products Affected

- NOROXIN

PA Criteria	Criteria Details
Covered Uses	Infection
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
Age Restrictions	less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	^ Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nor-QD

---

## Products Affected

- NOR-QD

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Northera

---

## Products Affected

- NORTHERA ORAL CAPSULE 100 MG

<b>QL Criteria</b>	3 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Northera

---

## Products Affected

- NORTHERA ORAL CAPSULE 200 MG, 300 MG

<b>QL Criteria</b>	6 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Nortrel 0.5/35 (28)

---

### Products Affected

- NORTREL 0.5/35 (28)

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nortrel 1/35 (21)

---

## Products Affected

- NORTREL 1/35 (21)

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nortrel 1/35 (28)

---

## Products Affected

- NORTREL 1/35 (28)

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nortrel 7/7/7

---

## Products Affected

- NORTREL 7/7/7

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Norvasc

---

## Products Affected

- NORVASC

<b>ST Criteria</b>	Trial of one month of generic amlodipine
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nova Max Glucose Test

---

## Products Affected

- NOVA MAX GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nucynta

---

## Products Affected

- NUCYNTA

<b>ST Criteria</b>	Trial of 2 days of immediate release oxycodone OR morphine
<b>QL Criteria</b>	180 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Nucynta ER

---

## Products Affected

- NUCYNTA ER

<b>QL Criteria</b>	60 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nuedexta

## Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	Pseudobulbar affect
Exclusion Criteria	
Required Medical Information	A documented diagnosis of pseudobulbar affect
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 caps Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# NuvaRing

---

## Products Affected

- NUVARING

<b>QL Criteria</b>	1 EA Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nuvigil

## Products Affected

- NUVIGIL ORAL TABLET 50 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Narcolepsy, confirmed by sleep lab evaluation (ROSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following: Member is currently using an oral/dental appliance Member has undergone an uvulopalatopharyngoplasty (UPPP) Member is greater than or equal to 65 yrs of age Member has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following: Member is compliant with and currently using CPAP/BiPAP treatment Member is experiencing excessive sleepiness despite CPAP/BiPAP use
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nuvigil

## Products Affected

- NUVIGIL ORAL TABLET 150 MG, 250 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Narcolepsy, confirmed by sleep lab evaluation (OSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following: Member is currently using an oral/dental appliance Member has undergone an uvulopalatopharyngoplasty (UPPP) Member is greater than or equal to 65 yrs of age Member has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following: Member is compliant with and currently using CPAP/BiPAP treatment Member is experiencing excessive sleepiness despite CPAP/BiPAP use
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nuvigil

## Products Affected

- NUVIGIL ORAL TABLET 200 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Narcolepsy, confirmed by sleep lab evaluation (OROSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following: Member is currently using an oral/dental appliance Member has undergone an uvulopalatopharyngoplasty (UPPP) Member is greater than or equal to 65 yrs of age Member has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following: Member is compliant with and currently using CPAP/BiPAP treatment Member is experiencing excessive sleepiness despite CPAP/BiPAP use
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Nymalize

## Products Affected

- NYMALIZE

PA Criteria	Criteria Details
Covered Uses	Subarachnoid hemorrhage
Exclusion Criteria	
Required Medical Information	A documented diagnosis of subarachnoid hemorrhage (SAH) in adults AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one week of the preferred generic alternative, nimodipine ORMember is unable to tolerate oral capsule or tablet
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	21 days
Other Criteria	
ST Criteria	A documented trial of one week of the preferred generic alternative, nimodipine
QL Criteria	2520 ml Per 21 days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ocella

---

## Products Affected

- OCELLA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Ocufen

---

## Products Affected

- OCUFEN

<b>QL Criteria</b>	6 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ocuflox

---

## Products Affected

- OCUFLOX

<b>QL Criteria</b>	1 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Odomzo

---

## Products Affected

- ODOMZO

<b>QL Criteria</b>	1 capsule Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: November 10, 2015

# Ofev

---

## Products Affected

- OFEV

<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ofloxacin

## Products Affected

- *ofloxacin oral*

PA Criteria	Criteria Details
Covered Uses	Infection
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cystic fibrosis with pulmonary infection due to P. aeruginosa, ORA documented diagnosis of a life-threatening infection due to P. aeruginosa untreatable by other first line antibiotics, ORA documented diagnosis of recurrent resistant urinary tract infection due to P. aeruginosa, ORMember needs prophylaxis or treatment of anthrax after known or suspected exposure (Cipro/ ciprofloxacin only), ORA documented diagnosis of complicated UTI and Pyelonephritis due to E. coli and is being used as second line treatment (Cipro/ ciprofloxacin only) ^
Age Restrictions	less than 10 years old
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	^ Note: Cipro tablets or oral suspension received FDA approval as second-line treatment of complicated urinary tract infections (cUTI) and pyelonephritis in pediatric patients 1 to 17 years of age. Per the manufacturer's package labeling, Cipro is not a drug of first choice in the pediatric population due to an increased incidence of adverse events related to joints and/or surrounding tissues.
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ofloxacin

---

## Products Affected

- *ofloxacin ophthalmic*

<b>QL Criteria</b>	1 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ofloxacin

---

## Products Affected

- *ofloxacin otic*

<b>QL Criteria</b>	2 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OLANZapine

---

## Products Affected

- *olanzapine oral tablet 15 mg, 10 mg, 20 mg, 7.5 mg, 5 mg*
- *olanzapine oral tablet dispersible*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# OLANZapine

---

## Products Affected

- *olanzapine oral tablet 2.5 mg*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OLANZapine-FLUOxetine HCl

---

## Products Affected

- *olanzapine-fluoxetine hcl*

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Olux

---

## Products Affected

- OLUX

<b>ST Criteria</b>	Trial of Two weeks of a generic clobetasol alternative
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Olux-E

---

## Products Affected

- OLUX-E

<b>ST Criteria</b>	Trial of Two weeks of a generic clobetasol alternative
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Olysio

---

## Products Affected

- OLYSIO

<b>QL Criteria</b>	1 capsule Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Omega-3-acid Ethyl Esters

---

## Products Affected

- *omega-3-acid ethyl esters*

<b>QL Criteria</b>	4 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Omeprazole

---

## Products Affected

- *omeprazole oral capsule delayed release*

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Omeprazole-Sodium Bicarbonate

---

## Products Affected

- *omeprazole-sodium bicarbonate oral capsule*  
40-1100 mg

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Omniflex Diaphragm

---

## Products Affected

- OMNIFLEX DIAPHRAGM

<b>QL Criteria</b>	1 diaphragm Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Omontys

---

## Products Affected

- OMONTYS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Anemia
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of anemia due to chronic kidney disease in adults with dialysis
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	4 months
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# On Call Express Blood Glucose

---

## Products Affected

- ON CALL EXPRESS BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# On Call Plus Blood Glucose

---

## Products Affected

- ON CALL PLUS BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# On Call Vivid Blood Glucose

---

## Products Affected

- ON CALL VIVID BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ondansetron

---

## Products Affected

- *ondansetron*

<b>QL Criteria</b>	12 tablets Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ondansetron

---

## Products Affected

- *ondansetron*

<b>QL Criteria</b>	12 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ondansetron HCl

---

## Products Affected

- *ondansetron hcl oral tablet 4 mg, 8 mg*

<b>QL Criteria</b>	12 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Ondansetron HCl

---

## Products Affected

- *ondansetron hcl oral tablet 24 mg*

<b>QL Criteria</b>	5 tablets Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ondansetron HCl

---

## Products Affected

- *ondansetron hcl oral solution*

<b>QL Criteria</b>	1 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OneTouch Test

---

## Products Affected

- ONETOUCH TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OneTouch Ultra Blue

---

## Products Affected

- ONETOUCH ULTRA BLUE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OneTouch Verio

---

## Products Affected

- ONETOUCH VERIO IN VITRO STRIP

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Onexton

---

## Products Affected

- ONEXTON

<b>ST Criteria</b>	Trial of ONE month of a preferred generic alternative, benzoyl peroxide/ clindamycin phosphate gel OR benzoyl peroxide/ erythromycin gel
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Onfi

---

## Products Affected

- ONFI ORAL TABLET

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Onglyza

---

## Products Affected

- ONGLYZA

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Onmel

## Products Affected

- ONMEL

PA Criteria	Criteria Details
<b>Covered Uses</b>	onychomycosis (Tinea unguium)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of onychomycosis (Tinea unguium) due to dermatophyte AND A documented positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis of onychomycosis (NOTE: This positive test should be recent (within the last 3-6 months) and associated with the current infection) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of 6 weeks of preferred generic terbinafine OR any of the following: Presence of hepatic dysfunction or increased risk for liver disease Fungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection) AND A documented contraindication or intolerance or allergy or failure of an adequate trial of 6 weeks of the preferred generic, itraconazole
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Opana ER

---

## Products Affected

- OPANA ER ORAL

<b>QL Criteria</b>	120 tablets Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Opsumit

---

## Products Affected

- OPSUMIT

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Options Conceptrol

---

## Products Affected

- OPTIONS CONCEPTROL

<b>QL Criteria</b>	15 units Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Options Gynol II Contraceptive

---

## Products Affected

- OPTIONS GYNOL II CONTRACEPTIVE

<b>QL Criteria</b>	15 units Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Optium Test

---

## Products Affected

- OPTIUM TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OptiumEZ Test

---

## Products Affected

- OPTIUMEZ TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OptumRx Blood Glucose Test

---

## Products Affected

- OPTUMRX BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Oracea

## Products Affected

- ORACEA

PA Criteria	Criteria Details
<b>Covered Uses</b>	Rosacea
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of Rosacea, ANDAge greater than 8 years old, ANDA documented contraindication or intolerance or allergy or failure of an adequate trial of fourteen days of the preferred alternative topical metronidazole OR generic doxycycline
<b>Age Restrictions</b>	greater than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oravig

---

## Products Affected

- ORAVIG

<b>QL Criteria</b>	14 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Orkambi

---

## Products Affected

- ORKAMBI

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Orsythia

---

## Products Affected

- ORSYTHIA

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ortho Diaphragm Coil

---

## Products Affected

- ORTHO DIAPHRAGM COIL

<b>QL Criteria</b>	1 kit Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ortho Diaphragm Flat

---

## Products Affected

- ORTHO DIAPHRAGM FLAT

<b>QL Criteria</b>	1 kit Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ortho Evra

---

## Products Affected

- ORTHO EVRA

<b>QL Criteria</b>	12 packages Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ortho Micronor

---

## Products Affected

- ORTHO MICRONOR

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Oseni

---

## Products Affected

- OSENI

<b>ST Criteria</b>	Trial of one month of pioglitazone in combination with two preferred brand products (Januvia, Onglyza, Tradjenta).
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oxtellar XR

---

## Products Affected

- OXTELLAR XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 150 MG, 300  
MG

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oxtellar XR

---

## Products Affected

- OXTELLAR XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 600 MG

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OxyCODONE HCl ER

---

## Products Affected

- *oxycodone hcl er*

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oxycodone-Ibuprofen

---

## Products Affected

- *oxycodone-ibuprofen*

<b>QL Criteria</b>	28 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# OxyCONTIN

---

## Products Affected

- OXYCONTIN

<b>QL Criteria</b>	120 tablets Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Oxymorphone HCl ER

---

## Products Affected

- *oxymorphone hcl er*

<b>QL Criteria</b>	120 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Paliperidone ER

---

## Products Affected

- *paliperidone er oral tablet extended release 24 hr\* 1.5 mg, 6 mg, 3 mg*

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Paliperidone ER

---

## Products Affected

- *paliperidone er oral tablet extended release 24 hr\* 9 mg*

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pantoprazole Sodium

---

## Products Affected

- *pantoprazole sodium oral*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Paragard Intrauterine Copper

---

## Products Affected

- PARAGARD INTRAUTERINE COPPER

<b>QL Criteria</b>	1 IUD Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PARoxetine HCl

---

## Products Affected

- *paroxetine hcl oral tablet 40 mg, 30 mg*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PARoxetine HCl

---

## Products Affected

- *paroxetine hcl oral tablet 20 mg, 10 mg*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PARoxetine HCl ER

---

## Products Affected

- *paroxetine hcl er*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Patanol

---

## Products Affected

- PATANOL

<b>ST Criteria</b>	Trial of ONEweek of Pataday
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Paxil

---

## Products Affected

- PAXIL ORAL TABLET 30 MG, 40 MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Paxil

---

## Products Affected

- PAXIL ORAL TABLET 20 MG, 10 MG

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Paxil

---

## Products Affected

- PAXIL ORAL SUSPENSION

<b>QL Criteria</b>	30 pen Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Paxil CR

---

## Products Affected

- PAXIL CR

<b>ST Criteria</b>	Trial of ONEmonth of generic alternative, paroxetine SR
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Penlac

## Products Affected

- PENLAC

PA Criteria	Criteria Details
<b>Covered Uses</b>	Onychomycosis due to dermatophyte
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) A documented diagnosis of onychomycosis confirmed by either a positive KOH stain (potassium hydroxide), positive PAS stain (para-aminosalicylic acid), a positive DTM (dermatophyte test medium) or positive fungal culture (positive test should be recent (within the last 3 - 6 months) and associated with the current infection) and, (2) a documented contraindication or intolerance or allergy or failure of an adequate trial of one systemic (oral) alternative either terbinafine (6 weeks for fingernail infections, 12 weeks for toenail infections), fluconazole (6 months), griseofulvin (6 months), itraconazole (60 days (PulsePak) for fingernail infections, 90 days for toenail) OR presence of hepatic dysfunction or increased risk for liver disease (for example, has a history of alcohol abuse or a history of hepatitis) OR member is female and is pregnant and/or breastfeeding, and (3) Member is NOT receiving a systemic (oral) antifungal agent - terbinafine, fluconazole, griseofulvin, itraconazole for onychomycosis at the same time.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Step therapy applies
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pennsaid

---

## Products Affected

- PENNSAID TRANSDERMAL SOLUTION  
1.5 %

<b>QL Criteria</b>	15 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pennsaid

---

## Products Affected

- PENNSAID TRANSDERMAL SOLUTION 2  
%

<b>QL Criteria</b>	4 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pentasa

---

## Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE\* 500 MG

<b>QL Criteria</b>	8 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pentasa

---

## Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE\* 250 MG

<b>QL Criteria</b>	16 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Perforomist

---

## Products Affected

- PERFOROMIST

<b>QL Criteria</b>	60 vials (120ml) Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pertzye

---

## Products Affected

- PERTZYE

<b>ST Criteria</b>	Trial of two weeks of two preferred alternative agents: CREON, ULTRASE, ULTRASE MT, ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pexeva

---

## Products Affected

- PEXEVA ORAL TABLET 10 MG, 20 MG

<b>ST Criteria</b>	Trial of paroxetine (NSO)
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pexeva

---

## Products Affected

- PEXEVA ORAL TABLET 40 MG, 30 MG

<b>ST Criteria</b>	Trial of paroxetine (NSO)
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pharmacist Choice Autocode

---

## Products Affected

- PHARMACIST CHOICE AUTOCODE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Philith

---

## Products Affected

- PHILITH

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Picato

---

## Products Affected

- PICATO

<b>QL Criteria</b>	1 tube Per 60 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pimtrea

---

## Products Affected

- PIMTREA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Pirmella 1/35

---

## Products Affected

- PIRMELLA 1/35

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pirmella 7/7/7

---

## Products Affected

- PIRMELLA 7/7/7

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Plaquenil

---

## Products Affected

- PLAQUENIL

<b>QL Criteria</b>	30 days minimum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Plavix

---

## Products Affected

- PLAVIX ORAL TABLET 75 MG

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Plegridy

---

## Products Affected

- PLEGRIDY

<b>QL Criteria</b>	1 ML Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Plegridy Starter Pack

---

## Products Affected

- PLEGRIDY STARTER PACK

<b>QL Criteria</b>	1 ML Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PocketChem EZ Test

---

## Products Affected

- POCKETCHEM EZ TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Polymyxin B-Trimethoprim

---

## Products Affected

- *polymyxin b-trimethoprim*

<b>QL Criteria</b>	1 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Polytrim

---

## Products Affected

- POLYTRIM

<b>QL Criteria</b>	1 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pomalyst

---

## Products Affected

- POMALYST

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Portia-28

---

## Products Affected

- PORTIA-28

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Potiga

---

## Products Affected

- POTIGA ORAL TABLET 400 MG, 300 MG, 200 MG

<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Potiga

---

## Products Affected

- POTIGA ORAL TABLET 50 MG

<b>QL Criteria</b>	6 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pradaxa

---

## Products Affected

- PRADAXA

<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Praluent

---

## Products Affected

- PRALUENT

<b>QL Criteria</b>	2 syringes Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pramipexole Dihydrochloride ER

---

## Products Affected

- *pramipexole dihydrochloride er oral tablet  
extended release 24 hr\* 4.5 mg*

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Prandin

---

## Products Affected

- PRANDIN

<b>ST Criteria</b>	Trial of ONE month of generic repaglinide
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pravachol

---

## Products Affected

- PRAVACHOL

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pravastatin Sodium

---

## Products Affected

- *pravastatin sodium*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Precision PCx

---

## Products Affected

- PRECISION PCX

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Precision PCX Plus Test

---

## Products Affected

- PRECISION PCX PLUS TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Precision Point of Care Test

---

## Products Affected

- PRECISION POINT OF CARE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Precision QID Test

---

## Products Affected

- PRECISION QID TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Precision Sof-Tact Test

---

## Products Affected

- PRECISION SOF-TACT TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Precision Xtra Blood Glucose

---

## Products Affected

- PRECISION XTRA BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pred-G

---

## Products Affected

- PRED-G

<b>QL Criteria</b>	15 pen Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prefest

---

## Products Affected

- PREFEST

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prentif Cavity-Rim Cerv Cap

---

## Products Affected

- PRENTIF CAVITY-RIM CERV CAP

<b>QL Criteria</b>	1 device Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prentif Fitting Set

---

## Products Affected

- PRENTIF FITTING SET

<b>QL Criteria</b>	1 device Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prestige Smart System Test

---

## Products Affected

- *prestige smart system test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prestige Test

---

## Products Affected

- PRESTIGE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prestige Value Pack

---

## Products Affected

- PRESTIGE VALUE PACK

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Prevacid

---

## Products Affected

- PREVACID ORAL CAPSULE DELAYED  
RELEASE 30 MG

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(1) Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: (a) The heartburn can be controlled by use of OTC medications, and (b) There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis, and (c) There are no symptoms of a more complicated GI condition (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), OR (2) Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications, OR (3) Any of the following diagnoses when NOT in combination with a diagnosis listed above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: (a) Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal) and (b) Member is experiencing acid breakthrough, OR (c) Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. **NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.</p>

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

<b>ST Criteria</b>	<p>Trial of ONEmonth each of ALL of the following preferred generic alternatives:  lansoprazole  an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate)  pantoprazole  AND ALL of the following preferred brands:  Dexilant  Nexium</p>
<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	<p>Prior Authorization: September 10, 2015  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# Prevacid SoluTab

---

## Products Affected

- PREVACID SOLUTAB

PA Criteria	Criteria Details
<b>Covered Uses</b>	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
<b>Exclusion Criteria</b>	(1) Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: (a) The heartburn can be controlled by use of OTC medications, and (b) There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis, and (c) There are no symptoms of a more complicated GI condition (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), OR (2) Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications, OR (3) Any of the following diagnoses when NOT in combination with a diagnosis listed above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: (a) Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal) and (b) Member is experiencing acid breakthrough, OR (c) Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. **NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.</p>

<b>ST Criteria</b>	Trial of ONEmonth each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Previfem

---

## Products Affected

- PREVIFEM

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PriLOSEC

---

## Products Affected

- PRILOSEC ORAL CAPSULE DELAYED RELEASE

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# PriLOSEC

---

## Products Affected

- PRILOSEC ORAL PACKET

<b>QL Criteria</b>	2 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pristiq

---

## Products Affected

- PRISTIQ

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pristiq

---

## Products Affected

- PRISTIQ

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ProAir HFA

---

## Products Affected

- PROAIR HFA

<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ProAir RespiClick

---

## Products Affected

- PROAIR RESPICLICK

<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ProCentra

## Products Affected

- PROCENTRA

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 14 days EACH of 3 of amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	40 ml Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Procysbi

---

## Products Affected

- PROCYSBI ORAL CAPSULE DELAYED  
RELEASE 25 MG

<b>QL Criteria</b>	4 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Procysbi

---

## Products Affected

- PROCYSBI ORAL CAPSULE DELAYED  
RELEASE 75 MG

<b>QL Criteria</b>	25 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Prodigy AutoCode Blood Glucose

---

## Products Affected

- PRODIGY AUTOCODE BLOOD GLUCOSE  
IN VITRO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Prodigy No Coding Blood Gluc

---

## Products Affected

- PRODIGY NO CODING BLOOD GLUC

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Promethazine HCl

## Products Affected

- *promethazine hcl suppository 25 mg, 12.5 mg*
- *promethazine hcl oral*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A AND C ? For promethazine tab/cap/supp/syrup, promethazine-dm, Prometh VC, promethegan and PhenerganB AND C ? For promethazine w/codeine, phenylephrine-promethazine-codeineA. Member is less than 2 years of ageORB. Member is less than 6 years of ageANDC. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	FDA alert6 Use of Phenergan/promethazine is contraindicated in Infants and Children less than 2 years of age, due to risks for fatal respiratory depression. In addition the use of promethazine and codeine (with or without phenylephrine) is contraindicated in pediatric patients less than 6 years of age
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Promethazine-Codeine

## Products Affected

- *promethazine-codeine*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A AND C ? For promethazine tab/cap/supp/syrup, promethazine-dm, Prometh VC, promethegan and PhenerganB AND C ? For promethazine w/codeine, phenylephrine-promethazine-codeineA. Member is less than 2 years of ageORB. Member is less than 6 years of ageANDC. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	FDA alert6 Use of Phenergan/promethazine is contraindicated in Infants and Children less than 2 years of age, due to risks for fatal respiratory depression. In addition the use of promethazine and codeine (with or without phenylephrine) is contraindicated in pediatric patients less than 6 years of age
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Promethazine-DM

## Products Affected

- *promethazine-dm*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A AND C ? For promethazine tab/cap/supp/syrup, promethazine-dm, Prometh VC, promethegan and Phenergan B AND C ? For promethazine w/codeine, phenylephrine-promethazine-codeine A. Member is less than 2 years of age ORB. Member is less than 6 years of age AND C. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	FDA alert 6 Use of Phenergan/promethazine is contraindicated in Infants and Children less than 2 years of age, due to risks for fatal respiratory depression. In addition the use of promethazine and codeine (with or without phenylephrine) is contraindicated in pediatric patients less than 6 years of age
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Promethegan

## Products Affected

- PROMETHEGAN

PA Criteria	Criteria Details
<b>Covered Uses</b>	Administration of analgesic: Prophylaxis Allergic condition Motion sickness Nausea and vomiting Postoperative pain Sedation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A AND C ? For promethazine tab/cap/supp/syrup, promethazine-dm, Prometh VC, promethegan and Phenergan B AND C ? For promethazine w/codeine, phenylephrine-promethazine-codeine A. Member is less than 2 years of age ORB. Member is less than 6 years of age AND C. Member's physician provides documentation (controlled clinical trial) from the peer reviewed medical literature that supports use in specified indication for this age group.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	FDA alert 6 Use of Phenergan/promethazine is contraindicated in Infants and Children less than 2 years of age, due to risks for fatal respiratory depression. In addition the use of promethazine and codeine (with or without phenylephrine) is contraindicated in pediatric patients less than 6 years of age
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Protonix

---

## Products Affected

- PROTONIX ORAL

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(1) Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: (a) The heartburn can be controlled by use of OTC medications, and (b) There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis, and (c) There are no symptoms of a more complicated GI condition (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), OR (2) Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications, OR (3) Any of the following diagnoses when NOT in combination with a diagnosis listed above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: (a) Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal) and (b) Member is experiencing acid breakthrough, OR (c) Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. **NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.</p>

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)



<b>ST Criteria</b>	<p>Trial of ONEmonth each of ALL of the following preferred generic alternatives:  lansoprazole  an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate)  pantoprazole  AND ALL of the following preferred brands:  Dexilant  Nexium</p>
<b>QL Criteria</b>	1 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	<p>Prior Authorization: September 10, 2015  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# Protonix

---

## Products Affected

- PROTONIX ORAL

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(1) Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: (a) The heartburn can be controlled by use of OTC medications, and (b) There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis, and (c) There are no symptoms of a more complicated GI condition (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), OR (2) Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications, OR (3) Any of the following diagnoses when NOT in combination with a diagnosis listed above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: (a) Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal) and (b) Member is experiencing acid breakthrough, OR (c) Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. **NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.</p>

<b>ST Criteria</b>	Trial of ONEmonth each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Protopic

## Products Affected

- PROTOPIC

PA Criteria	Criteria Details
Covered Uses	atopic dermatitis
Exclusion Criteria	
Required Medical Information	For Protopic 0.1% A documented diagnosis of atopic dermatitis (eczema) in an adult or an adolescent 16 years of age or older, AND one of the following: A documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, OR A documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, OR Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. For Protopic 0.03% A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months) (Note: requirement of a trial of topical corticosteroid is not required) OR A documented diagnosis of atopic dermatitis (eczema) in an adult or child 2 years of age or older, AND one of the following: A documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, OR A documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, OR Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas
Age Restrictions	?16 FOR 0.1%
Prescriber Restrictions	
Coverage Duration	Face, genital area: 3 months, Other body areas: 6 months, Patients less than 2 yrs : 3 months
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Proventil HFA

---

## Products Affected

- PROVENTIL HFA

<b>ST Criteria</b>	Trial of 1 week each of Ventolin HFA AND Proair
<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Provigil

## Products Affected

- PROVIGIL

PA Criteria	Criteria Details
<b>Covered Uses</b>	Narcolepsy, Obstructive sleep apnea/hypopnea syndrome (OSAHS), Shift Work Sleep Disorder (SWSD)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Narcolepsy, confirmed by sleep lab evaluation OROSAHS) confirmed by polysomnography (a study on sleep cycles and behavior) AND one of the following:Member is currently using an oral/dental applianceMember has undergone an uvulopalatopharyngoplasty (UPPP)Member is greater than or equal to 65 yrs of ageMember has already had an adequate therapeutic trial of twelve weeks of continuous positive airway pressure (CPAP)/ bilevel positive airway pressure (BiPAP) treatment and meets ALL of the following:Member is compliant with and currently using CPAP/BiPAP treatmentMember is experiencing excessive sleepiness despite CPAP/BiPAP use
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PROzac

---

## Products Affected

- PROZAC ORAL CAPSULE 40 MG

<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# PROzac

---

## Products Affected

- PROZAC ORAL CAPSULE 20 MG

<b>QL Criteria</b>	4 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PROzac

---

## Products Affected

- PROZAC ORAL CAPSULE 10 MG

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PROzac Weekly

---

## Products Affected

- PROZAC WEEKLY

<b>QL Criteria</b>	1 caps Per 7 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# PTS Panels Glucose Test

---

## Products Affected

- PTS PANELS GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Pulmicort Flexhaler

---

## Products Affected

- PULMICORT FLEXHALER

<b>ST Criteria</b>	Trial of 1 month of Asmanex, Qvar, OR Flovent/HFA
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Qualaquin

---

## Products Affected

- QUALAQUIN

<b>QL Criteria</b>	42 caps Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Quasense

---

## Products Affected

- QUASENSE

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Qudexy XR

---

## Products Affected

- QUDEXY XR

<b>QL Criteria</b>	1 capsule Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# QUetiapine Fumarate

---

## Products Affected

- *quetiapine fumarate oral tablet 100 mg, 50 mg*

<b>QL Criteria</b>	3 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# QUetiapine Fumarate

---

## Products Affected

- *quetiapine fumarate oral tablet 300 mg, 400 mg*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# QUetiapine Fumarate

---

## Products Affected

- *quetiapine fumarate oral tablet 200 mg*

<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# QUetiapine Fumarate

---

## Products Affected

- *quetiapine fumarate oral tablet 25 mg*

<b>QL Criteria</b>	6 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# QuickTek Test

---

## Products Affected

- QUICKTEK TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Quillivant XR

## Products Affected

- QUILLIVANT XR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 14 days EACH of 3 of amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	12 ML Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# QuiNINE Sulfate

---

## Products Affected

- *quinine sulfate oral*

<b>QL Criteria</b>	42 caps Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Quintet AC Blood Glucose Test

---

## Products Affected

- QUINTET AC BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Quintet Blood Glucose Test

---

## Products Affected

- QUINTET BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RA TRUEtest Test

---

## Products Affected

- RA TRUETEST TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RABEprazole Sodium

---

## Products Affected

- *rabeprazole sodium*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ranexa

---

## Products Affected

- RANEXA ORAL TABLET EXTENDED  
RELEASE 12 HR\* 1000 MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ranexa

---

## Products Affected

- RANEXA ORAL TABLET EXTENDED  
RELEASE 12 HR\* 500 MG

<b>QL Criteria</b>	3 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rapaflo

---

## Products Affected

- RAPAFLU

PA Criteria	Criteria Details
Covered Uses	Benign prostatic hyperplasia
Exclusion Criteria	
Required Medical Information	Member's physician provides documentation (controlled clinical trial) from the peer-reviewed medical literature for medical use in females
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Member is female
Notes/ References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rayos

---

## Products Affected

- RAYOS

<b>ST Criteria</b>	Trial of prednisone
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Reclast

---

## Products Affected

- RECLAST

<b>QL Criteria</b>	1 bottle Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Reclipsen

---

## Products Affected

- RECLIPSEN

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RefuAH Plus Blood Glucose Test

---

## Products Affected

- REFUAH PLUS BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Relenza Diskhaler

---

## Products Affected

- RELENZA DISKHALER

<b>QL Criteria</b>	2 EA Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ReliOn Blood Glucose Test

---

## Products Affected

- RELION BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ReliOn Confirm/micro Test

---

## Products Affected

- RELION CONFIRM/MICRO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ReliOn Prime Test

---

## Products Affected

- RELION PRIME TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ReliOn Ultima Test

---

## Products Affected

- RELION ULTIMA TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Relistor

## Products Affected

- RELISTOR SUBCUTANEOUS\* KIT

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid-induced constipation, ANDA documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), ANDMember is receiving palliative care, ANDConcomitant use of opioid therapy (i.e., codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone, propoxyphene or tramadol), ANDTrial and failure of two (2) laxatives (i.e., docusate sodium, Miralax, bisacodyl, lactulose, senna)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Relistor will be considered medically necessary for those members who meet ANY of the following criteria: Member requires dosing of one vial/syringe every other day (maximum quantity of 15 vials or 2 kits per 30 days).
QL Criteria	1 kit Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Relistor

## Products Affected

- RELISTOR SUBCUTANEOUS\* SOLUTION  
12 MG/0.6ML

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid-induced constipation
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of opioid-induced constipation, ANDA documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), ANDMember is receiving palliative care, ANDConcomitant use of opioid therapy (i.e., codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone, propoxyphene or tramadol), ANDTrial and failure of two (2) laxatives (i.e., docusate sodium, Miralax, bisacodyl, lactulose, senna)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Relistor will be considered medically necessary for those members who meet ANY of the following criteria: Member requires dosing of one vial/syringe every other day (maximum quantity of 15 vials or 2 kits per 30 days).
<b>QL Criteria</b>	10 vial Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Relistor

## Products Affected

- RELISTOR SUBCUTANEOUS\* SOLUTION  
8 MG/0.4ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation
Exclusion Criteria	
Required Medical Information	A documented diagnosis of opioid-induced constipation, ANDA documented diagnosis of an advanced illness (i.e., incurable cancer, end-stage COPD/emphysema, cardiovascular disease/heart failure, Alzheimer's disease/dementia, HIV/AIDS), ANDMember is receiving palliative care, ANDConcomitant use of opioid therapy (i.e., codeine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone, propoxyphene or tramadol), ANDTrial and failure of two (2) laxatives (i.e., docusate sodium, Miralax, bisacodyl, lactulose, senna)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of Relistor will be considered medically necessary for those members who meet ANY of the following criteria: Member requires dosing of one vial/syringe every other day (maximum quantity of 15 vials or 2 kits per 30 days).
QL Criteria	11 syringe Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Relpax

---

## Products Affected

- RELPAX

<b>ST Criteria</b>	Trial of ONE month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan (NSO)
<b>QL Criteria</b>	6 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Remeron

---

## Products Affected

- REMERON

<b>ST Criteria</b>	Trial of one month of generic mirtazapine OR mirtazapine ODT
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Remeron SolTab

---

## Products Affected

- REMERON SOLTAB

<b>ST Criteria</b>	Trial of one month of generic mirtazapine OR mirtazapine ODT
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Repatha

---

## Products Affected

- REPATHA

<b>QL Criteria</b>	2 syringes Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Repatha SureClick

---

## Products Affected

- REPATHA SURECLICK

<b>QL Criteria</b>	2 syringes Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Requip XL

---

## Products Affected

- REQUIP XL ORAL TABLET EXTENDED  
RELEASE 24 HR\* 8 MG, 4 MG, 6 MG, 2 MG

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Requip XL

---

## Products Affected

- REQUIP XL ORAL TABLET EXTENDED  
RELEASE 24 HR\* 12 MG

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rescula

---

## Products Affected

- RESCULA

<b>ST Criteria</b>	Trial of 1 week of latanoprost AND Travatan Z
<b>QL Criteria</b>	1 (5ml) bottle Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Retin-A

## Products Affected

- RETIN-A

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	greater than 35
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of one month each of two preferred alternatives indicated for the member's condition, one of which has to be tretinoin.
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Retin-A Micro

## Products Affected

- RETIN-A MICRO

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Retin-A Micro Pump

## Products Affected

- RETIN-A MICRO PUMP EXTERNAL 0.04  
%, 0.1 %

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of any one of the following:Acne vulgaris (includes comedonal, cystic, nodular & papular acne)Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	greater than 35
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Revatio

---

## Products Affected

- REVATIO ORAL SUSPENSION  
RECONSTITUTED

<b>QL Criteria</b>	2 bottles Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Revatio

---

## Products Affected

- REVATIO ORAL TABLET

<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Reveal Blood Glucose Test

---

## Products Affected

- REVEAL BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Rexall Blood Glucose Test

---

## Products Affected

- REXALL BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rexulti

---

## Products Affected

- REXULTI

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rightest GS100 Blood Glucose

---

## Products Affected

- RIGHTEST GS100 BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rightest GS300 Blood Glucose

---

## Products Affected

- RIGHTEST GS300 BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rightest GS550 Blood Glucose

---

## Products Affected

- RIGHTEST GS550 BLOOD GLUCOSE

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rilutek

## Products Affected

- RILUTEK

PA Criteria	Criteria Details
Covered Uses	amyotrophic lateral sclerosis (ALS)
Exclusion Criteria	
Required Medical Information	A documented diagnosis of amyotrophic lateral sclerosis (ALS) ANDA documented contraindication or intolerance or allergy or failure of an adequate trial of one month of the preferred generic equivalent alternative, riluzole
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	A documented trial of one month of the preferred generic equivalent alternative, riluzole
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Risedronate Sodium

---

## Products Affected

- *risedronate sodium oral tablet 35 mg*
- *risedronate sodium oral tablet delayed release*

<b>QL Criteria</b>	4 tablets Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Risedronate Sodium

---

## Products Affected

- *risedronate sodium oral tablet 5 mg, 30 mg*

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Risedronate Sodium

---

## Products Affected

- *risedronate sodium oral tablet 150 mg*

<b>QL Criteria</b>	1 tablet Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL

---

## Products Affected

- RISPERDAL ORAL TABLET 3 MG, 2 MG, 0.25 MG, 0.5 MG, 1 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL

---

## Products Affected

- RISPERDAL ORAL TABLET 4 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL M-TAB

---

## Products Affected

- RISPERDAL M-TAB ORAL TABLET  
DISPERSIBLE 0.5 MG, 1 MG, 2 MG, 3 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperDAL M-TAB

---

## Products Affected

- RISPERDAL M-TAB ORAL TABLET  
DISPERSIBLE 4 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperiDONE

---

## Products Affected

- *risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 0.25 mg, 3 mg*
- *risperidone oral tablet 0.25 mg, 2 mg, 0.5 mg, 1 mg, 3 mg*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperiDONE

---

## Products Affected

- *risperidone oral tablet dispersible 4 mg*
- *risperidone oral tablet 4 mg*

<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# RisperiDONE M-TAB

---

## Products Affected

- RISPERIDONE M-TAB ORAL TABLET  
DISPERSIBLE 4 MG

<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# RisperiDONE M-TAB

---

## Products Affected

- RISPERIDONE M-TAB ORAL TABLET  
DISPERSIBLE 2 MG, 0.5 MG, 1 MG, 3 MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ritalin

## Products Affected

- RITALIN

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 14 days EACH of 3 of amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	3 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ritalin LA

---

## Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED  
RELEASE 24 HOUR 60 MG

<b>QL Criteria</b>	1 capsule Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ritalin LA

## Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 20 MG, 10 MG, 40 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 14 days EACH of 3 of amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	1 caps Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ritalin LA

## Products Affected

- RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 30 MG

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 14 days EACH of 3 of amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	2 caps Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ritalin SR

## Products Affected

- RITALIN SR

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 14 days EACH of 3 of amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
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

# Rizatriptan Benzoate

---

## Products Affected

- *rizatriptan benzoate*

<b>QL Criteria</b>	12 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rizatriptan Benzoate

---

## Products Affected

- *rizatriptan benzoate*

<b>QL Criteria</b>	12 Blisters Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# ROPINIRole HCl ER

---

## Products Affected

- *ropinirole hcl er oral tablet extended release*  
24 hr\* 2 mg, 6 mg, 8 mg, 4 mg

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ROPINIRole HCl ER

---

## Products Affected

- *ropinirole hcl er oral tablet extended release*  
*24 hr\* 12 mg*

<b>QL Criteria</b>	12 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Rozerem

---

## Products Affected

- ROZEREM

<b>ST Criteria</b>	Trial of 7 days (one week) of the preferred generic alternative zolpidem OR zolpidem er.
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sabril

---

## Products Affected

- SABRIL ORAL PACKET

<b>QL Criteria</b>	6 packets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sabril

---

## Products Affected

- SABRIL ORAL TABLET

<b>QL Criteria</b>	6 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sanctura

---

## Products Affected

- SANCTURA

<b>ST Criteria</b>	Trial of ONE month of ONEof trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sancuso

---

## Products Affected

- SANCUSO

<b>QL Criteria</b>	1 patch Per 21 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Saphris

---

## Products Affected

- SAPHRIS

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Saphris

---

## Products Affected

- SAPHRIS

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Savaysa

---

## Products Affected

- SAVAYSA

<b>ST Criteria</b>	Trial of ONE month Eliquis AND Xarelto
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Savella

---

## Products Affected

- SAVELLA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Savella Titration Pack

---

## Products Affected

- SAVELLA TITRATION PACK

<b>QL Criteria</b>	55 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Seasonique

---

## Products Affected

- SEASONIQUE

<b>QL Criteria</b>	90 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Semprex-D

## Products Affected

- SEMPREX-D

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than $\geq$ 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
<b>QL Criteria</b>	4 caps Per 1 Day
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

# Sentry Test

---

## Products Affected

- *sentry test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Serevent Diskus

---

## Products Affected

- SEREVENT DISKUS

<b>QL Criteria</b>	1 box Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel

---

## Products Affected

- SEROQUEL ORAL TABLET 50 MG, 100 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	3 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel

---

## Products Affected

- SEROQUEL ORAL TABLET 25 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	6 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel

---

## Products Affected

- SEROQUEL ORAL TABLET 200 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel

---

## Products Affected

- SEROQUEL ORAL TABLET 300 MG, 400 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel XR

---

## Products Affected

- SEROQUEL XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 300 MG, 400  
MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel XR

---

## Products Affected

- SEROQUEL XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 200 MG, 150  
MG

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SEROquel XR

---

## Products Affected

- SEROQUEL XR ORAL TABLET  
EXTENDED RELEASE 24 HR\* 50 MG

<b>QL Criteria</b>	6 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Sertraline HCl

---

## Products Affected

- *sertraline hcl oral concentrate*

<b>QL Criteria</b>	10 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sertraline HCl

---

## Products Affected

- *sertraline hcl oral tablet 50 mg*

<b>QL Criteria</b>	45 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sertraline HCl

---

## Products Affected

- *sertraline hcl oral tablet 100 mg*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sertraline HCl

---

## Products Affected

- *sertraline hcl oral tablet 25 mg*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Shoprite Test

---

## Products Affected

- *shoprite test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Shur-Seal Contraceptive

---

## Products Affected

- SHUR-SEAL CONTRACEPTIVE

<b>QL Criteria</b>	15 units Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Signifor

---

## Products Affected

- SIGNIFOR

<b>QL Criteria</b>	10 Ampules Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Signifor LAR

---

## Products Affected

- SIGNIFOR LAR

<b>QL Criteria</b>	1 injection Per 28 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Sildenafil Citrate

---

## Products Affected

- *sildenafil citrate oral*

<b>QL Criteria</b>	3 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Silenor

---

## Products Affected

- SILENOR

<b>ST Criteria</b>	Trial of 7 days (one week) each of generic doxepin AND zolpidem OR zolpidem er
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Simcor

---

## Products Affected

- SIMCOR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 500-40 MG, 1000-40 MG

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Simcor

---

## Products Affected

- SIMCOR ORAL TABLET EXTENDED  
RELEASE 24 HR\* 750-20 MG, 1000-20 MG,  
500-20 MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Simponi

---

## Products Affected

- SIMPONI

<b>QL Criteria</b>	1 syringe Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Simvastatin

---

## Products Affected

- *simvastatin oral*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Singular

---

## Products Affected

- SINGULAIR

<b>QL Criteria</b>	1 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Singular

---

## Products Affected

- SINGULAIR

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Sirturo

## Products Affected

- SIRTURO

PA Criteria	Criteria Details
<b>Covered Uses</b>	pulmonary multi-drug resistant tuberculosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of pulmonary multi-drug resistant tuberculosis (MDR-TB) in adults AND all of the following: Member has failed or is failing an adequate treatment regimen* consisting of at least 4 drugs, administered under directly observed therapy (DOT) (or serum medication levels have been documented) or an adequate treatment regimen consisting of at least 4 drugs cannot otherwise be provided (Note: Treatment failure is defined as continuous or recurrently positive sputum cultures during the course of appropriate antituberculous therapy) Drug susceptibility testing for first and second-line agents will be performed and therapy will be initiated in combination with at least 3 other drugs which have shown susceptibility Treatment will be administered under directly observed therapy (DOT) An electrocardiogram (ECG) will be obtained before initiation of treatment, and at least 2, 12, and 24 weeks after starting treatment
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	24 weeks
<b>Other Criteria</b>	According to the manufacturer, 400 mg of Sirturo should be taken daily for 2 weeks, then 200 mg of Sirturo should be taken three times weekly for 22 weeks. A quantity of this drug will be considered medically necessary as indicated in the table below if member fulfills above criteria:

<b>ST Criteria</b>	<p>A documented trial of at least three months of the preferred treatment regimen consisting of at least 2 of the following:</p> <ul style="list-style-type: none"> <li>ethambutol</li> <li>pyrazinamide</li> <li>Trecator (ethionamide)</li> <li>cycloserine</li> <li>Paser (aminosalicylic acid)</li> <li>amoxicillin/ clavulanate</li> <li>imipenem/ cilastatin</li> <li>clarithromycin</li> <li>Zyvox</li> </ul> <p>And 1 of the following:</p> <ul style="list-style-type: none"> <li>Avelox (moxifloxacin)</li> <li>levofloxacin</li> <li>ofloxacin</li> </ul> <p>And 1 of the following:</p> <ul style="list-style-type: none"> <li>amikacin</li> <li>capreomycin</li> <li>kanamycin</li> <li>streptomycin</li> </ul>
<b>QL Criteria</b>	68 tablets Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015  Step Therapy: August 25, 2015  Quantity Limits: August 25, 2015</p>

# Sivextro

## Products Affected

- SIVEXTRO ORAL

PA Criteria	Criteria Details
Covered Uses	Infection of skin AND/OR subcutaneous tissue
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acute bacterial skin and skin structure infections (ABSSSI), and Culture and susceptibility information or, in the absence of such data, local epidemiology and susceptibility patterns indicate that the current infection is caused by one of the following Gram-positive microorganisms: Staph. aureus (including methicillin-resistant [MRSA] and methicillin-susceptible [MSSA] isolates), or Strep. pyogenes, or Strep. agalactiae, or Strep. anginosus Group (including Strep. anginosus, Strep. intermedius, and Strep. constellatus), or E. faecalis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
QL Criteria	6 tablets Per 30 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Skelid

---

## Products Affected

- SKELID

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Skyla

---

## Products Affected

- SKYLA

<b>QL Criteria</b>	1 Device Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Smart Diabetes Xpres Test

---

## Products Affected

- SMART DIABETES XPRES TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Smart Sense Premium Test

---

## Products Affected

- SMART SENSE PREMIUM TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Smart Sense Value Test

---

## Products Affected

- SMART SENSE VALUE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Smartest Blood Glucose Test

---

## Products Affected

- SMARTEST BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Solia

---

## Products Affected

- SOLIA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Solodyn

## Products Affected

- SOLODYN

PA Criteria	Criteria Details
<b>Covered Uses</b>	All FDA Covered Indications
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	For ALL tetracyclines(If less than 8 years of age)A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
<b>Age Restrictions</b>	less than 8 years old
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Solus V2 Test

---

## Products Affected

- SOLUS V2 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sonata

---

## Products Affected

- SONATA ORAL CAPSULE 5 MG

<b>ST Criteria</b>	Trial of 7 days (one week) of the preferred generic alternative zolpidem OR zolpidem er.
<b>QL Criteria</b>	4 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sonata

---

## Products Affected

- SONATA ORAL CAPSULE 10 MG

<b>ST Criteria</b>	Trial of 7 days (one week) of the preferred generic alternative zolpidem OR zolpidem er.
<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sovaldi

---

## Products Affected

- SOVALDI

<b>QL Criteria</b>	28 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Spiriva HandiHaler

---

## Products Affected

- SPIRIVA HANDIHALER

<b>QL Criteria</b>	1 box Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Spiriva Respimat

---

## Products Affected

- SPIRIVA RESPIMAT INHALATION  
AEROSOL, SOLUTION 1.25 MCG/ACT

<b>QL Criteria</b>	1 inhaler Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Spiriva Respimat

---

## Products Affected

- SPIRIVA RESPIMAT INHALATION  
AEROSOL, SOLUTION 2.5 MCG/ACT

<b>QL Criteria</b>	1 inhaler Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sporanox

## Products Affected

- SPORANOX

PA Criteria	Criteria Details
<b>Covered Uses</b>	Aspergillosis, Invasive, salvage therapy Blastomycosis Candidiasis of the esophagus Histoplasmosis, Disseminated Onychomycosis due to dermatophyte Oropharyngeal candidiasis Pulmonary histoplasmosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the below indications and specified criteria AND A documented contraindication/intolerance/allergy/failure of an adequate trial of generic itraconazole (if request is for brand Sporanox)AspergillosisBlastomycosisTreatment of oropharyngeal/esophageal candidiasis in HIV-infected personsChromoblastomycosisCoccidioidomycosis associated with AIDS, treatment and prophylaxisCryptococcosisCryptococcal meningitis - HIV infectionCutaneous dermatophyte infection: NOTE: tinea pedis/manuum (athletes foot/hand), tinea cruris (jock itch), or tinea corporis (ringworm on the body), does NOT include tinea versicolor] ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of one topical antifungal AND preferred generic oral terbinafineFebrile neutropeniaHistoplasmosisPenicillium marneffeii infectionProphylaxis of invasive fungal infections in persons with Chronic Granulomatous Disease, hematologic malignancies or liver transplantsDisseminated microsporidiosis caused by Trachipleistophora or Brachiola species in HIV-infected personsOnychomycosis (Tinea unguium) due to dermatophyte ANDA documented positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis of onychomycosis (NOTE: This positive test should be recent (within the last 3-6 months) and associated with the current infection)AND A documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of preferred generic terbinafine OR any of the following:Presence of hepatic dysfunction or increased risk for liver diseaseFungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection)ParacoccidioidomycosisSporotrichosisTinea versicolorTinea capitis AND A documented contraindication/intolerance/allergy/failure of two weeks of generic terbinafineVulvovaginal Candidiasis
<b>Age Restrictions</b>	

PA Criteria	Criteria Details
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sporanox Pulsepak

## Products Affected

- SPORANOX PULSEPAK

PA Criteria	Criteria Details
<b>Covered Uses</b>	Aspergillosis, Invasive, salvage therapy Blastomycosis Candidiasis of the esophagus Histoplasmosis, Disseminated Onychomycosis due to dermatophyte Oropharyngeal candidiasis Pulmonary histoplasmosis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the below indications and specified criteria AND A documented contraindication/intolerance/allergy/failure of an adequate trial of generic itraconazole (if request is for brand Sporanox)AspergillosisBlastomycosisTreatment of oropharyngeal/esophageal candidiasis in HIV-infected personsChromoblastomycosisCoccidioidomycosis associated with AIDS, treatment and prophylaxisCryptococcosisCryptococcal meningitis - HIV infectionCutaneous dermatophyte infection: NOTE: tinea pedis/manuum (athletes foot/hand), tinea cruris (jock itch), or tinea corporis (ringworm on the body), does NOT include tinea versicolor] ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of one topical antifungal AND preferred generic oral terbinafineFebrile neutropeniaHistoplasmosisPenicillium marneffeii infectionProphylaxis of invasive fungal infections in persons with Chronic Granulomatous Disease, hematologic malignancies or liver transplantsDisseminated microsporidiosis caused by Trachipleistophora or Brachiola species in HIV-infected personsOnychomycosis (Tinea unguium) due to dermatophyte ANDA documented positive laboratory test such as (potassium hydroxide-KOH preparation, fungal culture, or nail biopsy) to confirm the diagnosis of onychomycosis (NOTE: This positive test should be recent (within the last 3-6 months) and associated with the current infection)ANDA documented contraindication/intolerance/allergy/failure of an adequate trial of 6 weeks of preferred generic terbinafine OR any of the following:Presence of hepatic dysfunction or increased risk for liver diseaseFungal culture indicating lack of sensitivity to terbinafine Non-dermatophyte fungal infection (mixed infection, a mold or yeast infection)ParacoccidioidomycosisSporotrichosisTinea versicolorTinea capitis AND A documented contraindication/intolerance/allergy/failure of two weeks of generic terbinafineVulvovaginal Candidiasis
<b>Age Restrictions</b>	

PA Criteria	Criteria Details
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sprintec 28

---

## Products Affected

- SPRINTEC 28

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sprix

---

## Products Affected

- SPRIX

<b>QL Criteria</b>	5 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Sprycel

---

## Products Affected

- SPRYCEL

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sronyx

---

## Products Affected

- SRONYX

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Stimate

## Products Affected

- STIMATE

PA Criteria	Criteria Details
Covered Uses	Diagnosis of hemophilia A or mild to moderate von Willebrand's disease (vWd)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Stiolto Respimat

---

## Products Affected

- STIOLTO RESPIMAT

<b>QL Criteria</b>	1 inhaler Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Stivarga

---

## Products Affected

- STIVARGA

<b>QL Criteria</b>	21 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Strattera

---

## Products Affected

- STRATTERA ORAL CAPSULE 100 MG, 80 MG

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Strattera

---

## Products Affected

- STRATTERA ORAL CAPSULE 40 MG, 60 MG, 25 MG, 10 MG, 18 MG

<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Striant

## Products Affected

- STRIANT

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	2 buccals Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

2015 Aetna Pharmacy Plan Drug List - Premier  
 (Updated 12/01/15)



# Stribild

## Products Affected

- STRIBILD

PA Criteria	Criteria Details
<b>Covered Uses</b>	human immunodeficiency virus (HIV)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of human immunodeficiency virus (HIV)A documented resistance test within the past 3 months demonstrating virologic susceptibility to all of the following components of Stribild: elvitegravir, emtricitabine, and tenofovir AND A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Atripla (efavirenz-emtricitabine-tenofovir) or a documented resistance test within the past 3 months demonstrating virologic resistance to efavirenz ORA documented contraindication or intolerance or allergy or failure of an adequate trial of one month of Truvada, Reyataz, and Norvir (emtricitabine-tenofovir, atazanavir, ritonavir) in combination or documented resistance test within the past 3 months demonstrating virological resistance to atazanavir ORA documented viral load assay AND CD4 count indicating that the patient is stable on Stribild (stable or increase in CD4 counts AND viral load less than 50 copies/ml) (FOR renewals ONLY)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Striverdi Respimat

---

## Products Affected

- STRIVERDI RESPIMAT

<b>QL Criteria</b>	1 inhaler Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Suboxone

---

## Products Affected

- SUBOXONE SUBLINGUAL FILM 12-3 MG

<b>QL Criteria</b>	2 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Suboxone

---

## Products Affected

- SUBOXONE SUBLINGUAL FILM 4-1 MG, 2-0.5 MG, 8-2 MG

<b>QL Criteria</b>	90 pack Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Suboxone

---

## Products Affected

- SUBOXONE SUBLINGUAL TABLET  
SUBLINGUAL

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Subsys

## Products Affected

- SUBSYS SUBLINGUAL LIQUID† 100 MCG

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer pain, General anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)AND Documentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process</p>

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

<b>ST Criteria</b>	Trial of one week of generic fentanyl transmucosal lozenge
<b>QL Criteria</b>	15 ml Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Subsys

---

## Products Affected

- SUBSYS SUBLINGUAL LIQUID† 200 MCG, 600 MCG, 800 MCG, 400 MCG

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer pain, General anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year



PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)AND Documentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process</p>
<b>ST Criteria</b>	Trial of one week of generic fentanyl transmucosal lozenge
<b>QL Criteria</b>	15 pack Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Subsys

---

## Products Affected

- SUBSYS SUBLINGUAL LIQUID† 1200 (600 X 2) MCG, 1600 (800 X 2) MCG

PA Criteria	Criteria Details
Covered Uses	Breakthrough cancer pain, General anesthesia
Exclusion Criteria	
Required Medical Information	A documented diagnosis of cancer AND concomitant use of long acting opioid therapy or member's resident state or contract state is California and the member is terminally ill
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>The member has a documented diagnosis of cancer and the prescription is written by an oncologist or pain specialist, OR the member is enrolled in a hospice program or meets hospice criteria, OR the member's resident state or contract state is California and the member is terminally ill, OR the patient has signed an opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine. (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)AND Documentation of one of the following: Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement. *Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program) Member has current diagnosis of cancer(*see exception to opioid agreement above) as the primary cause of the pain and is currently on long-acting opioid and is being titrated on the long-acting opioid by physicianANDMember has tried and failed an adequate trial of two weeks of a single entity or combination pain medication containing an immediate release acting opioid (ex. oxycodone, morphine sulfate oral(Roxanol): oxymorphone(Opana): hydromorphone(Dilaudid): oxycodone/apap(Percocet))NOTE: Diffuse to pharmacist for further review. Pharmacist approval for titration is based on member information and education of provider. Requests for additional quantities beyond pharmacist approval will be directed to the appeals process</p>
<b>ST Criteria</b>	Trial of one week of generic fentanyl transmucosal lozenge
<b>QL Criteria</b>	8 pack Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: September 08, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sulfacetamide Sodium

---

## Products Affected

- *sulfacetamide sodium ophthalmic solution*

<b>QL Criteria</b>	3 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SulfaSALazine

---

## Products Affected

- *sulfasalazine oral*

<b>QL Criteria</b>	8 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sulfazine

---

## Products Affected

- SULFAZINE

<b>QL Criteria</b>	8 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sulfazine EC

---

## Products Affected

- SULFAZINE EC

<b>QL Criteria</b>	8 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SUMAtriptan Succinate

---

## Products Affected

- *sumatriptan succinate oral*

<b>QL Criteria</b>	9 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Sumavel DosePro

---

## Products Affected

- SUMAVEL DOSEPRO

<b>ST Criteria</b>	Trial of ONE month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan (NSO)
<b>QL Criteria</b>	6 syringe Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sumavel DosePro

---

## Products Affected

- SUMAVEL DOSEPRO

<b>ST Criteria</b>	Trial of ONE month of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan (NSO)
<b>QL Criteria</b>	6 syringes Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Supreme Test

---

## Products Affected

- SUPREME TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sure Edge Test

---

## Products Affected

- SURE EDGE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SureChek Blood Glucose Test

---

## Products Affected

- SURECHEK BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SureStep Pro Test

---

## Products Affected

- SURESTEP PRO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SureStep Test

---

## Products Affected

- SURESTEP TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Sure-Test EasyPlus Mini Test

---

## Products Affected

- SURE-TEST EASYPLUS MINI TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Sutent

---

## Products Affected

- SUTENT

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Syeda

---

## Products Affected

- SYEDA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Symbicort

---

## Products Affected

- SYMBICORT

<b>QL Criteria</b>	1 inhaler Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Symbyax

---

## Products Affected

- SYMBYAX

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SymlinPen 120

---

## Products Affected

- SYMLINPEN 120

PA Criteria	Criteria Details
Covered Uses	Diabetes
Exclusion Criteria	
Required Medical Information	A documented diagnosis of type I or type II diabetes AND Concurrent use of a rapid or short-acting insulin i.e., Humalog or regular insulin
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# SymlinPen 60

---

## Products Affected

- SYMLINPEN 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Covered Uses</b>	Diabetes
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of type I or type II diabetes AND Concurrent use of a rapid or short-acting insulin i.e., Humalog or regular insulin
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Synjardy

---

## Products Affected

- SYNJARDY

<b>ST Criteria</b>	Trial of 1 month of Invokana (single entity or combination)
<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tacrolimus

## Products Affected

- *tacrolimus external*

PA Criteria	Criteria Details
Covered Uses	atopic dermatitis
Exclusion Criteria	
Required Medical Information	For Protopic 0.1% A documented diagnosis of atopic dermatitis (eczema) in an adult or an adolescent 16 years of age or older, AND one of the following: A documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, OR A documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, OR Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas. For Protopic 0.03% A documented diagnosis of mild to moderate atopic dermatitis (eczema) in patients less than 2 years of age for short-term use (up to 3 months) (Note: requirement of a trial of topical corticosteroid is not required) OR A documented diagnosis of atopic dermatitis (eczema) in an adult or child 2 years of age or older, AND one of the following: A documented contraindication, intolerance or allergy to one preferred alternative topical corticosteroid indicated for the patient's condition, OR A documented failure of an adequate trial of 2 weeks (14 days) of one preferred alternative topical corticosteroid indicated for the patient's condition, OR Treatment is in an area at high risk for skin atrophy such as face, eyelids, or genital areas
Age Restrictions	?16 FOR 0.1%
Prescriber Restrictions	
Coverage Duration	Face, genital area: 3 months, Other body areas: 6 months, Patients less than 2 yrs : 3 months
Other Criteria	
QL Criteria	60 GM Per 1 fill
Notes/References	
Revision Date	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)



# Tafinlar

---

## Products Affected

- TAFINLAR

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tamiflu

---

## Products Affected

- TAMIFLU ORAL CAPSULE 45 MG, 30 MG

<b>QL Criteria</b>	20 caps Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tamiflu

---

## Products Affected

- TAMIFLU ORAL CAPSULE 75 MG

<b>QL Criteria</b>	2 pack Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tamiflu

---

## Products Affected

- TAMIFLU ORAL SUSPENSION  
RECONSTITUTED 6 MG/ML

<b>QL Criteria</b>	480 pen Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tanzeum

## Products Affected

- TANZEUM

PA Criteria	Criteria Details
Covered Uses	Type II diabetes
Exclusion Criteria	no personal or family history of medullary thyroid carcinoma (MTC),OR, Multiple Endocrine Neoplasia syndrome type 2 (MEN 2)
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 1 month Each of Bydureon AND Victoza
QL Criteria	4 pens Per 28 Days
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tarceva

---

## Products Affected

- TARCEVA

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tasigna

---

## Products Affected

- TASIGNA

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tazorac

---

## Products Affected

- TAZORAC

PA Criteria	Criteria Details
Covered Uses	acne vulgaris plaque psoriasis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of acne vulgaris, ORA documented diagnosis of plaque psoriasis
Age Restrictions	greater than 35 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Tecfidera

---

## Products Affected

- TECFIDERA ORAL

<b>QL Criteria</b>	1 starter pack Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tecfidera

---

## Products Affected

- TECFIDERA ORAL CAPSULE DELAYED  
RELEASE 240 MG

<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tecfidera

---

## Products Affected

- TECFIDERA ORAL CAPSULE DELAYED  
RELEASE 120 MG

<b>QL Criteria</b>	14 capsules Per 7 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Technivie

---

## Products Affected

- TECHNIVIE

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tekamlo

---

## Products Affected

- TEKAMLO

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tekturna

---

## Products Affected

- TEKTURNA

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tekturna HCT

---

## Products Affected

- TEKTURNA HCT ORAL TABLET 150-12.5 MG, 150-25 MG

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Telcare Blood Glucose Test

---

## Products Affected

- TELCARE BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Temodar

---

## Products Affected

- TEMODAR ORAL

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Temozolomide

---

## Products Affected

- *temozolomide*

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Testim

## Products Affected

- TESTIM

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	10 GM Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Testosterone

## Products Affected

- *testosterone transdermal 50 mg/5gm (1%)*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	60 packets Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Testosterone

---

## Products Affected

- *testosterone transdermal 10 mg/act (2%)*

<b>QL Criteria</b>	4 pumps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Testosterone

---

## Products Affected

- *testosterone transdermal 25 mg/2.5gm (1%)*

<b>QL Criteria</b>	2.5 GM Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Testosterone

## Products Affected

- *testosterone transdermal 12.5 mg/act (1%)*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>QL Criteria</b>	4 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Tetrabenazine

---

## Products Affected

- *tetrabenazine oral tablet 25 mg*

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Tetrabenazine

---

## Products Affected

- *tetrabenazine oral tablet 12.5 mg*

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Teveten

## Products Affected

- TEVETEN ORAL TABLET 600 MG

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension, ANDA documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any three preferred generic alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan, eprosartan, irbesartan, losartan, valsartan, OR telmisartan
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Teveten HCT

## Products Affected

- TEVETEN HCT

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Step Therapy
ST Criteria	Trial of one month each of any three preferred alternatives from the following as a single entity or hydrochlorothiazide combination product: candesartan eprosartan irbesartan losartan valsartan telmisartan
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TGT Blood Glucose Test

---

## Products Affected

- *tgt blood glucose test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TiaGABine HCl

---

## Products Affected

- *tia gabine hcl oral tablet 4 mg*

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TiaGABine HCl

---

## Products Affected

- *tia gabine hcl oral tablet 2 mg*

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tilia Fe

---

## Products Affected

- TILIA FE

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tivorbex

---

## Products Affected

- TIVORBEX

<b>QL Criteria</b>	3 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# TobraDex

---

## Products Affected

- TOBRADEX OPHTHALMIC SUSPENSION

<b>QL Criteria</b>	1 pen Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TobraDex ST

---

## Products Affected

- TOBRADEX ST

<b>QL Criteria</b>	1 pen Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tobramycin

---

## Products Affected

- *tobramycin ophthalmic*

<b>QL Criteria</b>	3 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tobramycin-Dexamethasone

---

## Products Affected

- *tobramycin-dexamethasone*

<b>QL Criteria</b>	1 pen Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tobrex

---

## Products Affected

- TOBREX OPHTHALMIC SOLUTION

<b>QL Criteria</b>	3 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Today Sponge

---

## Products Affected

- TODAY SPONGE

<b>QL Criteria</b>	10 devices Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Topamax Sprinkle

---

## Products Affected

- TOPAMAX SPRINKLE

<b>QL Criteria</b>	4 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Topiramate

---

## Products Affected

- *topiramate oral capsule sprinkle*

<b>QL Criteria</b>	4 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Toviaz

---

## Products Affected

- TOVIAZ

<b>ST Criteria</b>	Trial of ONE month of ONE of trospium/ er, tolteridine/ er AND ONE of Enablex, Myrbetriq, Vesicare
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tradjenta

---

## Products Affected

- TRADJENTA

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TraMADol HCl ER

---

## Products Affected

- *tramadol hcl er oral capsule extended release*  
24 hour 100 mg, 300 mg, 200 mg

<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tranexamic Acid

---

## Products Affected

- *tranexamic acid oral*

<b>QL Criteria</b>	30 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Travatan Z

---

## Products Affected

- TRAVATAN Z

<b>QL Criteria</b>	90 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Travoprost

---

## Products Affected

- *travoprost*

<b>QL Criteria</b>	3 ML Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretinoin

---

## Products Affected

- *tretinoin oral*

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretinoin

## Products Affected

- *tretinoin external*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of any one of the following:Acne vulgaris (includes comedonal, cystic, nodular & papular acne)Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	greater than 35
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of one month each of two preferred alternatives indicated for the member's condition, one of which has to be tretinoin.
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Tretinoin

## Products Affected

- *tretinoin external*

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretinoin Microsphere

## Products Affected

- *tretinoin microsphere*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	greater than 35
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretinoin Microsphere Pump

## Products Affected

- *tretinoin microsphere pump*

PA Criteria	Criteria Details
<b>Covered Uses</b>	Acne vulgaris
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of any one of the following: Acne vulgaris (includes comedonal, cystic, nodular & papular acne) Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoin Hypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not tolerated Keratosis follicularis (Darier's disease, Darier-White disease) Facial flat warts Multiple flat warts (includes common warts and plantar warts)
<b>Age Restrictions</b>	greater than 35
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tretin-X

## Products Affected

- TRETIN-X EXTERNAL CREAM

PA Criteria	Criteria Details
Covered Uses	Acne vulgaris
Exclusion Criteria	
Required Medical Information	A documented diagnosis of any one of the following:Acne vulgaris (includes comedonal, cystic, nodular & papular acne)Actinic keratoses AND Lesions are on the face OR Lesions are not on the face and therapy includes the use of 5-fluorouracil in conjunction with tretinoinHypertrophic scars or keloids AND Intralesional injection of corticosteroids is ineffective or not toleratedKeratosis follicularis (Darier's disease, Darier-White disease)Facial flat wartsMultiple flat warts (includes common warts and plantar warts)
Age Restrictions	greater than 35
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of one month each of two preferred alternatives indicated for the member's condition, one of which has to be tretinoin.
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Treximet

---

## Products Affected

- TREXIMET

<b>ST Criteria</b>	Trial of ONEmonth of 3 of the following: naratriptan, rizatriptan, sumatriptan, zolmitriptan AND concurrent use of prescription strength naproxen $\geq$ 500mg (NSO)
<b>QL Criteria</b>	9 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tribenzor

## Products Affected

- TRIBENZOR

PA Criteria	Criteria Details
Covered Uses	hypertension
Exclusion Criteria	
Required Medical Information	A documented diagnosis of hypertension, ANDA documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of any two preferred alternatives from the following:candesartan/hctz, in combination with amlodipine, eprosartan/hctz, in combination with amlodipine, irbesartan/hctz, in combination with amlodipine, losartan/hctz, in combination with amlodipine, telmisartan/hctz in combination with amlodipine, valsartan/hctz in combination with amlodipine, telmisartan/ amlodipine in combination with hctz OR Exforge HCT
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tricor

---

## Products Affected

- TRICOR

<b>ST Criteria</b>	Trial of one month of any preferred fenofibrate product
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tri-Estarylla

---

## Products Affected

- TRI-ESTARYLLA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Trifluridine

---

## Products Affected

- *trifluridine ophthalmic*

<b>QL Criteria</b>	3 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Triglide

---

## Products Affected

- TRIGLIDE ORAL TABLET 160 MG

<b>ST Criteria</b>	Trial of one month of any preferred fenofibrate product
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tri-Legest Fe

---

## Products Affected

- TRI-LEGEST FE

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tri-Linyah

---

## Products Affected

- TRI-LINYAH

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Trilipix

---

## Products Affected

- TRILIPIX

<b>ST Criteria</b>	Trial of one month of any preferred fenofibrate product
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TriNessa (28)

---

## Products Affected

- TRINESSA (28)

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tri-Previfem

---

## Products Affected

- TRI-PREVIFEM

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tri-Sprintec

---

## Products Affected

- TRI-SPRINTEC

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Trivora (28)

---

## Products Affected

- TRIVORA (28)

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Trokendi XR

---

## Products Affected

- TROKENDI XR ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 100 MG,  
25 MG, 50 MG

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Trokendi XR

---

## Products Affected

- TROKENDI XR ORAL CAPSULE  
EXTENDED RELEASE 24 HOUR 200 MG

<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# True Care Test Strip Pack

---

## Products Affected

- *true care test strip pack*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TRUEtest Test

---

## Products Affected

- TRUETEST TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# TrueTrack Test

---

## Products Affected

- TRUETRACK TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Trulicity

---

## Products Affected

- TRULICITY SUBCUTANEOUS\* 1.5  
MG/0.5ML

<b>QL Criteria</b>	4 injections Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Truvada

## Products Affected

- TRUVADA

PA Criteria	Criteria Details
<b>Covered Uses</b>	human immunodeficiency virus (HIV)
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of human immunodeficiency virus (HIV) OR A documented diagnosis of initiating therapy for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults at high risk AND documentation of all of the following: A negative HIV antibody test taken: Immediately before starting Truvada for PrEP AND Every 3 months thereafter while on therapy Confirmation that creatinine clearance value greater than $\geq 60$ mL/min before initiating Truvada for PrEP AND Serum creatinine and calculate creatinine clearance checks performed at 3 months after initiation and then every 6 months thereafter NOTE: Members may receive a 30 days' supply of medication upon initial request of Truvada for PrEP diagnosis. After 30 days, above criteria must be met.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	PrEP- 3 months (renewals approved pending HIV testing and CrCl value), HIV- 1 year
<b>Other Criteria</b>	
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 13, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Tudorza Pressair

---

## Products Affected

- TUDORZA PRESSAIR

<b>QL Criteria</b>	1 pack Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Twinject

---

## Products Affected

- TWINJECT INJECTION 0.15 MG/0.15ML

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Tykerb

---

## Products Affected

- TYKERB

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Uceris

---

## Products Affected

- UCERIS

<b>ST Criteria</b>	Trial of Asacol HD, Delzicol, Lialda OR Pentasa
<b>QL Criteria</b>	4 canisters Per 42 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Uceris

## Products Affected

- UCERIS ORAL

PA Criteria	Criteria Details
Covered Uses	ulcerative colitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of active, mild to moderate ulcerative colitis and a documented contraindication or intolerance or allergy or failure of an adequate trial of one month each of two preferred 5-ASA therapies (i.e., balsalazide, Canasa, Delzicol) and one preferred generic corticosteroid therapy (i.e., budesonide sr, prednisone, prednisolone)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 months
Other Criteria	
QL Criteria	1 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Uloric

---

## Products Affected

- ULORIC

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ultima Test

---

## Products Affected

- ULTIMA TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# UltraTRAK PRO Test

---

## Products Affected

- ULTRATRAK PRO TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# UltraTRAK Ultimate Test

---

## Products Affected

- ULTRATRAK ULTIMATE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ultresa

---

## Products Affected

- ULTRESA

<b>ST Criteria</b>	Trial of two weeks of two preferred alternative agents: CREON, ULTRASE, ULTRASE MT, ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Unistrip1 Generic

---

## Products Affected

- UNISTRIP1 GENERIC

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valcyte

---

## Products Affected

- VALCYTE ORAL SOLUTION  
RECONSTITUTED

<b>QL Criteria</b>	1000 ml Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valcyte

---

## Products Affected

- VALCYTE ORAL TABLET

<b>QL Criteria</b>	102 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ValGANciclovir HCl

---

## Products Affected

- *valganciclovir hcl*

<b>QL Criteria</b>	102 tablets Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valsartan-Hydrochlorothiazide

---

## Products Affected

- *valsartan-hydrochlorothiazide oral tablet*  
*160-25 mg, 160-12.5 mg, 80-12.5 mg*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Valtrex

---

## Products Affected

- VALTRESX

<b>ST Criteria</b>	Trial of one week of generic valacyclovir
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Vascepa

---

## Products Affected

- VASCEPA

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# VCF Vaginal Contraceptive

---

## Products Affected

- VCF VAGINAL CONTRACEPTIVE VAGINAL FOAM
- VCF VAGINAL CONTRACEPTIVE VAGINAL FILM

<b>QL Criteria</b>	15 units Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vecamyl

---

## Products Affected

- VECAMYL

<b>QL Criteria</b>	10 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Velivet

---

## Products Affected

- VELIVET

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venlafaxine HCl

---

## Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

<b>QL Criteria</b>	3 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venlafaxine HCl

---

## Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venlafaxine HCl

---

## Products Affected

- *venlafaxine hcl oral tablet 50 mg*

<b>QL Criteria</b>	6 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venlafaxine HCl

---

## Products Affected

- *venlafaxine hcl oral tablet 75 mg*

<b>QL Criteria</b>	5 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Venlafaxine HCl ER

---

## Products Affected

- *venlafaxine hcl er oral tablet extended release*  
24 hr\* 225 mg

<b>ST Criteria</b>	Trial of venlafaxine (NSO)
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venlafaxine HCl ER

---

## Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 37.5 mg, 75 mg*

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Venlafaxine HCl ER

---

## Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ventolin HFA

---

## Products Affected

- VENTOLIN HFA

<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Verdeso

---

## Products Affected

- VERDESO

<b>ST Criteria</b>	Trial of two weeks of generic desonide: any dosage form
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Versacloz

---

## Products Affected

- VERSACLOZ

<b>ST Criteria</b>	Trial of clozapine (NSO)
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vestura

---

## Products Affected

- VESTURA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vibramycin

## Products Affected

- VIBRAMYCIN

PA Criteria	Criteria Details
Covered Uses	All FDA Covered Indications
Exclusion Criteria	
Required Medical Information	For ALL tetracyclines(If less than 8 years of age)A documented rare infectious diagnosis that requires use of tetracyclines in young children (examples include juvenile periodontitis or Mediterranean spotted fever)(Note: Tetracyclines should not be used in children younger than 8 years of age unless other appropriate drugs are ineffective or are contraindicated. American Academy of Pediatrics (AAP), US Centers for Disease Control and Prevention (CDC), and Infectious Diseases Society of America (IDSA) state that use of tetracyclines in children younger than 8 years of age can be considered in certain circumstances when the benefits outweigh the risks)
Age Restrictions	less than 8 years old
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Victory AGM-4000 Test

---

## Products Affected

- VICTORY AGM-4000 TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Victoza

---

## Products Affected

- VICTOZA

<b>QL Criteria</b>	3 pen Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Victrelis

---

## Products Affected

- VICTRELIS

<b>QL Criteria</b>	12 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vigamox

---

## Products Affected

- VIGAMOX

<b>QL Criteria</b>	5 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viibryd

---

## Products Affected

- VIIBRYD

<b>QL Criteria</b>	1 kit Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viibryd

---

## Products Affected

- VIIBRYD

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viibryd Starter Pack

## Products Affected

- VIIBRYD STARTER PACK

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	For coverage of additional quantities: Member requires a dose including half tablets OR Member's dose is being titrated by physician (3-month limit) OR Member has had intolerance to drug administered as a single daily dose OR Member's dose cannot be achieved with proposed qty limits for a given strength (ex. Mm needs 375mg per day and would require 5 capsules of venlafaxine sr cap or Effexor XR 75mg to achieve dose.)Covered for fully insured member in the state of CT who requires the prescribed drug for the diagnosis of gender dysphoria, as defined in the most recent edition DSM V.
ST Criteria	Trial of 3 different antidepressants from at least two different therapeutic subclasses, i.e., SSRIs (fluoxetine, citalopram), SNRIs (duloxetine, venlafaxine), TCAs (amitriptyline, nortriptyline), heterocyclic antidepressants (mirtazapine, trazodone) (NSO)
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vimovo

---

## Products Affected

- VIMOVO

<b>ST Criteria</b>	Trial of two weeks of one preferred generic nonsteroidal anti-inflammatory agent
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Vimpat

---

## Products Affected

- VIMPAT ORAL SOLUTION

<b>QL Criteria</b>	40 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vimpat

---

## Products Affected

- VIMPAT ORAL TABLET 50 MG

<b>QL Criteria</b>	6 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vimpat

---

## Products Affected

- VIMPAT ORAL TABLET 150 MG, 100 MG, 200 MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viokace

---

## Products Affected

- VIOKACE

<b>ST Criteria</b>	Trial of two weeks of two preferred alternative agents: CREON, ULTRASE, ULTRASE MT, ZENPEP
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viorele

---

## Products Affected

- *viorele*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viramune

---

## Products Affected

- VIRAMUNE

<b>ST Criteria</b>	Trial of one month of the medication's preferred generic equivalent alternative
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Viroptic

---

## Products Affected

- VIROPTIC

<b>QL Criteria</b>	3 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vivelle-Dot

---

## Products Affected

- VIVELLE-DOT

<b>QL Criteria</b>	8 patch Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Vocal Point Blood Glucose Test

---

## Products Affected

- VOCAL POINT BLOOD GLUCOSE TEST

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vogelxo

## Products Affected

- VOGELXO

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	60 packets Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

2015 Aetna Pharmacy Plan Drug List - Premier  
 (Updated 12/01/15)

# Vogelxo Pump

## Products Affected

- VOGELXO PUMP

PA Criteria	Criteria Details
<b>Covered Uses</b>	Primary hypogonadism or hypogonadotropic hypogonadism
<b>Exclusion Criteria</b>	<ol style="list-style-type: none"> <li>1. female members</li> <li>2. patient is male with carcinoma of the breast or suspected carcinoma of the prostate</li> <li>3. patient will be using therapy for muscle building purposes</li> </ol>
<b>Required Medical Information</b>	<p>Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: 1. Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), OR: 2. Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), OR For persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available)Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>ST Criteria</b>	Trial of ONE month each of AndroGel AND Testim
<b>QL Criteria</b>	4 pumps Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	<p>Prior Authorization: August 25, 2015            Step Therapy: August 25, 2015            Quantity Limits: August 25, 2015</p>

# Voltaren

---

## Products Affected

- VOLTAREN TRANSDERMAL

<b>QL Criteria</b>	5 tubes Per 30 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Votrient

---

## Products Affected

- VOTRIENT

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vyfemla

---

## Products Affected

- VYFEMLA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vytorin

---

## Products Affected

- VYTORIN

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Vyvanse

---

## Products Affected

- VYVANSE

<b>QL Criteria</b>	1 capsule Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Vyvanse

---

## Products Affected

- VYVANSE

<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# WaveSense Presto

---

## Products Affected

- WAVESENSE PRESTO

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wellbutrin

---

## Products Affected

- WELLBUTRIN

<b>QL Criteria</b>	6 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wellbutrin SR

---

## Products Affected

- WELLBUTRIN SR

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wellbutrin XL

---

## Products Affected

- WELLBUTRIN XL

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wera

---

## Products Affected

- WERA

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 60

---

## Products Affected

- WIDE-SEAL DIAPHRAGM 60

<b>QL Criteria</b>	1 diaphragm Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 65

---

## Products Affected

- WIDE-SEAL DIAPHRAGM 65

<b>QL Criteria</b>	1 diaphragm Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Wide-Seal Diaphragm 70

---

## Products Affected

- WIDE-SEAL DIAPHRAGM 70

<b>QL Criteria</b>	1 diaphragm Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 75

---

## Products Affected

- WIDE-SEAL DIAPHRAGM 75

<b>QL Criteria</b>	1 diaphragm Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 80

---

## Products Affected

- WIDE-SEAL DIAPHRAGM 80

<b>QL Criteria</b>	1 diaphragm Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 85

---

## Products Affected

- WIDE-SEAL DIAPHRAGM 85

<b>QL Criteria</b>	1 diaphragm Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 90

---

## Products Affected

- WIDE-SEAL DIAPHRAGM 90

<b>QL Criteria</b>	1 diaphragm Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wide-Seal Diaphragm 95

---

## Products Affected

- WIDE-SEAL DIAPHRAGM 95

<b>QL Criteria</b>	1 diaphragm Per 365 days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Winn Dixie Medic Test

---

## Products Affected

- *winn dixie medic test*

<b>QL Criteria</b>	300 EA Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Wymzya Fe

---

## Products Affected

- WYMZYA FE

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Xalatan

---

## Products Affected

- XALATAN

<b>ST Criteria</b>	Trial of 1 week of latanoprost AND Travatan Z
<b>QL Criteria</b>	3 ML Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xalkori

---

## Products Affected

- XALKORI

<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xanax XR

---

## Products Affected

- XANAX XR

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xarelto

---

## Products Affected

- XARELTO ORAL TABLET 15 MG

<b>QL Criteria</b>	42 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xarelto

---

## Products Affected

- XARELTO ORAL TABLET 20 MG

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xarelto

---

## Products Affected

- XARELTO ORAL TABLET 10 MG

<b>QL Criteria</b>	35 tab Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xarelto Starter Pack

---

## Products Affected

- XARELTO STARTER PACK

<b>QL Criteria</b>	2 packs Per 325 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xeljanz

---

## Products Affected

- XELJANZ

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Xeloda

---

## Products Affected

- XELODA

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xenazine

---

## Products Affected

- XENAZINE ORAL TABLET 25 MG

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xenazine

---

## Products Affected

- XENAZINE ORAL TABLET 12.5 MG

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xifaxan

## Products Affected

- XIFAXAN ORAL TABLET 200 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever) OR hepatic encephalopathy
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever)ORA documented diagnosis of hepatic encephalopathyANDA documented:Contraindication to one preferred alternative agent indicated for the member's condition ORIntolerance to one preferred alternative agent indicated for the member's condition ORAllergy to one preferred alternative agent indicated for the member's condition ORFailure of an adequate trial of two weeks of one preferred alternative agent indicated for the member's condition
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Hepatic encephalopathy: One year Traveler's Diarrhea: 1 Week
<b>Other Criteria</b>	
<b>QL Criteria</b>	9 tab Per 30 Days
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xifaxan

## Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	Traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever) OR hepatic encephalopathy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of traveler's diarrhea caused by noninvasive strains of Escherichia coli (non-bloody diarrhea without fever)ORA documented diagnosis of hepatic encephalopathyANDA documented:Contraindication to one preferred alternative agent indicated for the member's condition ORIntolerance to one preferred alternative agent indicated for the member's condition ORAllergy to one preferred alternative agent indicated for the member's condition ORFailure of an adequate trial of two weeks of one preferred alternative agent indicated for the member's condition
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Hepatic encephalopathy: One year Traveler's Diarrhea: 1 Week
Other Criteria	
QL Criteria	2 tab Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xigduo XR

---

## Products Affected

- XIGDUO XR

<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xopenex HFA

---

## Products Affected

- XOPENEX HFA

<b>ST Criteria</b>	Trial of 1 week each of Ventolin HFA AND Proair
<b>QL Criteria</b>	2 inhalers Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xtandi

---

## Products Affected

- XTANDI

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Xyrem

## Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	Cataplexy and narcolepsy, Narcolepsy to treat excessive daytime sleepiness
Exclusion Criteria	
Required Medical Information	Member and physician are enrolled in the Xyrem Success Program, and (1) Member has a documented diagnosis of narcolepsy confirmed by sleep lab evaluation, or (2) Member has episodes of cataplexy including hypnagogic hallucinations and/or sleep paralysis, or (c) Member has excessive daytime sleepiness with symptoms that limit the ability to perform normal daily activities.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	18 ml Per 1 Day
Notes/References	
Revision Date	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Xyzal

## Products Affected

- XYZAL ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
Exclusion Criteria	
Required Medical Information	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than $\geq$ 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
QL Criteria	10 ml Per 1 Day
Notes/References	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

# Xyzal

## Products Affected

- XYZAL ORAL TABLET

PA Criteria	Criteria Details
<b>Covered Uses</b>	Idiopathic urticaria, chronic Perennial allergic rhinitis Seasonal allergic rhinitis
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented diagnosis of one of the following: FDA-approved indications: Allergic conjunctivitis Chronic idiopathic urticaria (hives) Rhinitis (allergic perennial or seasonal, vasomotor) Accepted unlabeled indications listed in the pharmaceutical compendia (United States Pharmacopeia Drug Information or American Hospital Formulary Service): allergies angioedema asthma atopic dermatitis (eczema) dermatographism mastocytosis pruritus can be caused for example by (atopic dermatitis i.e eczema, or contact dermatitis ) urticaria (hives) transfusion reactions urticarial, anaphylactic/anaphylactoid reactions ANDA documented: contraindication or intolerance or allergy or failure of two weeks each of TWO of the following nonprescription (OTC) products (single entity or combination product): one containing loratadine, one containing fexofenadine or one containing cetirizine OR Member is a child less than $\geq$ 2 years of age - For Clarinex and desloratadine, ONLY OR Member is pregnant AND failed TWO nonprescription (OTC) products: one containing loratadine (single entity or combination product) AND the other containing cetirizine (single entity or combination product) - For levocetirizine, Xyzal - ONLY
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	Note: levocetirizine, loratadine, Alavert, cetirizine, Claritin, Xyzal and Zyrtec are designated as Pregnancy Category B: Allegra, Clarinex, desloratadine and fexofenadine are designated as Pregnancy Category C
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/References</b>	

<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015
----------------------	---

# Zaleplon

---

## Products Affected

- *zaleplon oral capsule 10 mg*

<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zaleplon

---

## Products Affected

- *zaleplon oral capsule 5 mg*

<b>QL Criteria</b>	4 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zarah

---

## Products Affected

- ZARAH

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zecuity

---

## Products Affected

- ZECUITY

<b>QL Criteria</b>	4 patches Per 1 month
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zegerid

---

## Products Affected

- ZEGERID ORAL CAPSULE 40-1100 MG

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(1) Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: (a) The heartburn can be controlled by use of OTC medications, and (b) There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis, and (c) There are no symptoms of a more complicated GI condition (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), OR (2) Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications, OR (3) Any of the following diagnoses when NOT in combination with a diagnosis listed above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: (a) Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal) and (b) Member is experiencing acid breakthrough, OR (c) Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. **NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.</p>

<b>ST Criteria</b>	Trial of ONEmonth each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium
<b>QL Criteria</b>	1 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zegerid

---

## Products Affected

- ZEGERID ORAL PACKET

PA Criteria	Criteria Details
Covered Uses	Gastroesophageal reflux disease, Duodenal ulcer disease, Gastric hypersecretion
Exclusion Criteria	(1) Uncomplicated heartburn of greater than 1-month duration, with a frequency of at least 2 heartburn episodes per week when all of the following criteria are met: (a) The heartburn can be controlled by use of OTC medications, and (b) There is no diagnosis of more complicated acid reflux disease, such as erosive esophagitis, and (c) There are no symptoms of a more complicated GI condition (such as trouble or pain swallowing food, vomiting with blood, bloody or black stools, heartburn of more than 3 months duration, heartburn with lightheadedness, sweating, dizziness, chest pain or shoulder pain with shortness of breath, sweating, pain spreading to arms, neck, or shoulders, frequent chest pain, frequent wheezing, particularly with heartburn.unexplained weight loss, nausea or vomiting, or stomach pain), OR (2) Uncomplicated heartburn with a frequency of less than 1 episode/week that can be controlled by use of OTC medications, OR (3) Any of the following diagnoses when NOT in combination with a diagnosis listed above: Dyspepsia, Gastritis or duodenitis, Gastroparesis, Gastric bypass surgery(surgical prophylaxis only), Hiatal hernia, Schatzki's ring (esophagogastric ring).

PA Criteria	Criteria Details
<b>Required Medical Information</b>	<p>A documented diagnosis of one of the following: Ulcers, Gastrojejunal ulcer (active, maintenance), Healing of NSAID-associated gastric ulcer, Maintenance of healed duodenal ulcers, Stress ulcer/surgical prophylaxis, Treatment of benign gastric ulcer, Treatment of duodenal ulcers, Other GI Conditions, Gastric residual reduction, Gastrointestinal bleed, GERD - moderate to severe with symptoms, GERD- with atypical symptoms or complications (i.e. dysphagia, hoarseness, asthma exacerbations, non-cardiac chest pain, esophageal stricture), Healing erosive esophagitis, Helicobacter pylori eradication to reduce risk of duodenal ulcer recurrence (additional documentation of two concurrent antibiotics (i.e. amoxicillin or clarithromycin or metronidazole or tetracycline) that will be used in the treatment regimen combined with the requested PPI as part of the therapy are required), Maintaining healing of erosive esophagitis, or Pathologic hypersecretory conditions (i.e. Barretts, Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1). Medication can also be approved when the member is using it for preventative measures for one of the following: (a)Member is on chronic oral corticosteroid therapy (greater than or equal to 60 days), (b)Member is post transplant and/or MD is a transplant specialist, (c)Member is receiving chemotherapy or radiation therapy for a current cancer diagnosis, or (d)Reducing risk of NSAID-associated gastric ulcer. Medication can also be approved if member is intolerance to the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC) or had had a failure of an adequate trial of two weeks of the nonprescription Prilosec OTC 20mg and Prevacid 24 hour 15 mg (OTC).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>For coverage of additional quantities, a member's treating physician must request prior authorization through the Pharmacy Management Precertification Unit. Additional quantities of proton pump inhibitors may be considered medically necessary for those members who meet ANY of the following criteria: (1) Member has a diagnosis of a pathological hypersecretory condition (e.g., Zollinger-Ellison Syndrome, multiple endocrine neoplasia type 1 (MEN-1)), or (2) Member is being treated for Barrett's esophagus, or (3) Member is being treated for eradication of H. pylori (triple therapy only, 30-day duration), or (4) Member has refractory gastroesophageal reflux disease (GERD) (defined as continued symptoms despite PPI therapy) and meets ALL the following criteria: (a) Member has had at least 4 wks of once daily PPI therapy taken 30-60 min before a meal (any meal) and (b) Member is experiencing acid breakthrough, OR (c) Member's physician provides documentation (controlled clinical trial) from the peer- reviewed medical literature for use of a higher dose. **NOTE: 20 mg prescription Prilosec capsules are excluded from coverage for most members.</p>

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

<b>ST Criteria</b>	Trial of ONEmonth each of ALL of the following preferred generic alternatives: lansoprazole an omeprazole product (i.e. omeprazole or omeprazole/sodium bicarbonate) pantoprazole AND ALL of the following preferred brands: Dexilant Nexium
<b>QL Criteria</b>	1 pack Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: September 10, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zelapar

---

## Products Affected

- ZELAPAR

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zelboraf

---

## Products Affected

- ZELBORAF

<b>QL Criteria</b>	8 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zenatane

## Products Affected

- ZENATANE ORAL CAPSULE 10 MG, 40 MG, 20 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	severe recalcitrant nodular or cystic acne
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Member already has evidence of scarring, AND member is enrolled in the FDA iPLEDGE program
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	For coverage of additional quantities (greater than 2 capsules per day) member must meet the following criteria: 1. Patient requires more than 2 capsules per day to reach the appropriate dose for weight, AND2. This is the members FIRST course of therapy OR member now requires a second course of therapy and it has been at least 8 weeks after the first course was initiated (2 month "holiday), AND3. Member has recieved a cumulative dose of LESS THAN 120 mg/kg during a course of therapy lasting 20 weeks or less.
<b>QL Criteria</b>	2 capsules Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: August 31, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zenchant

---

## Products Affected

- ZENCHENT

<b>QL Criteria</b>	1.5 tablet Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zenchant FE

---

## Products Affected

- ZENCHENT FE

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zenzedi

## Products Affected

- ZENZEDI

PA Criteria	Criteria Details
Covered Uses	Attention deficit hyperactivity disorder (ADHD) Narcolepsy
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of 14 days EACH of 3 of amphetamine/dextroamphetamine/ sr, dexamethylphenidate/ sr, dextroamphetamine, methamphetamine, methylphenidate/ er/ sr, Strattera, OR Vyvanse
QL Criteria	4 tablets Per 1 Day
Notes/References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zenzedi

---

## Products Affected

- ZENZEDI

<b>QL Criteria</b>	4 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zeosa

---

## Products Affected

- ZEOSA

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zerit

---

## Products Affected

- ZERIT

<b>ST Criteria</b>	Trial of one month of the medication's preferred generic equivalent alternative
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zetia

---

## Products Affected

- ZETIA

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zetonna

---

## Products Affected

- ZETONNA

<b>ST Criteria</b>	Trial of 2 weeks each of 2 of Nasonex, Veramyst, budesonide, flunisolide, fluticasone, OR triamcinolone
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ziagen

---

## Products Affected

- ZIAGEN

<b>ST Criteria</b>	Trial of one month of the medication's preferred generic equivalent alternative
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zioptan

---

## Products Affected

- ZIOPTAN

<b>ST Criteria</b>	Trial of 1 week of latanoprost AND Travatan Z
<b>QL Criteria</b>	1 unit Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Ziprasidone HCl

---

## Products Affected

- *ziprasidone hcl*

<b>QL Criteria</b>	2 caps Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zocor

---

## Products Affected

- ZOCOR

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zofran

---

## Products Affected

- ZOFRAN ORAL SOLUTION

<b>QL Criteria</b>	1 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zofran

---

## Products Affected

- ZOFRAN ORAL TABLET

<b>QL Criteria</b>	12 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zofran ODT

---

## Products Affected

- ZOFRAN ODT

<b>QL Criteria</b>	12 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zohydro ER

## Products Affected

- ZOHYDRO ER ORAL

PA Criteria	Criteria Details
<b>Covered Uses</b>	moderate to severe pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	A documented progression through the World Health Organization analgesic ladder
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	<p>A Documented diagnosis of cancer and prescription is written by an oncologist or pain specialist OR</p> <p>Member is enrolled in a hospice program or meets hospice criteria OR</p> <p>Member's resident state or contract state is California and the member is terminally ill OR</p> <p>Patient has signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (Note: ALL additional quantities above what is allowed in the chart above require that a Patient have a signed opioid agreement in support of clinical guidelines by the American Pain Society and the American Academy of Pain Medicine (note: bullets below have examples of these agreements as reference)</p> <p>Healthcare Provider verbal confirmation that an agreement has been signed by the patient meets the criteria requirement.</p> <p>*Exceptions to requiring the signed opioid agreement for additional quantities above what are in the chart above are only for those patients that have a diagnosis of cancer or that are enrolled in a hospice program)</p> <p>AND</p> <p>Documentation of one of the following: A documented diagnosis of moderate to severe chronic pain</p> <p>AND</p> <p>formal pain evaluation has been documented</p> <p>AND</p> <p>Other pain management regimens have been inadequate</p>
<b>QL Criteria</b>	2 capsules Per 1 Day

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoledronic Acid

---

## Products Affected

- *zoledronic acid intravenous\* concentrate*

<b>QL Criteria</b>	1 vial Per 21 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoledronic Acid

---

## Products Affected

- *zoledronic acid intravenous\* solution 5 mg/100ml*

<b>QL Criteria</b>	1 bottle Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zolinza

---

## Products Affected

- ZOLINZA

<b>QL Criteria</b>	30 days maximum Per 1 fill
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZOLMitriptan

---

## Products Affected

- *zolmitriptan oral*

<b>QL Criteria</b>	6 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoloft

---

## Products Affected

- ZOLOFT ORAL TABLET 100 MG

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zoloft

---

## Products Affected

- ZOLOFT ORAL CONCENTRATE

<b>QL Criteria</b>	10 ml Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoloft

---

## Products Affected

- ZOLOFT ORAL TABLET 50 MG

<b>QL Criteria</b>	45 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zoloft

---

## Products Affected

- ZOLOFT ORAL TABLET 25 MG

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zolpidem Tartrate

---

## Products Affected

- *zolpidem tartrate oral tablet 5 mg*

<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zolpidem Tartrate

---

## Products Affected

- *zolpidem tartrate oral tablet 10 mg*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zolpidem Tartrate ER

---

## Products Affected

- *zolpidem tartrate er*

<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zolpimist

---

## Products Affected

- ZOLPIMIST

<b>ST Criteria</b>	Trial of 7 days (one week) of the preferred generic alternative zolpidem OR zolpidem er.
<b>QL Criteria</b>	1 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zometa

---

## Products Affected

- ZOMETA INTRAVENOUS\* SOLUTION

<b>QL Criteria</b>	1 vial Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zometa

---

## Products Affected

- ZOMETA INTRAVENOUS\*  
CONCENTRATE

<b>QL Criteria</b>	1 vial Per 21 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig

---

## Products Affected

- ZOMIG NASAL SOLUTION 2.5 MG

<b>QL Criteria</b>	6 ml Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig

---

## Products Affected

- ZOMIG NASAL SOLUTION 5 MG

<b>QL Criteria</b>	1 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig

---

## Products Affected

- ZOMIG ORAL

<b>QL Criteria</b>	6 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zomig ZMT

---

## Products Affected

- ZOMIG ZMT

<b>QL Criteria</b>	6 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zorvolex

---

## Products Affected

- ZORVOLEX

<b>QL Criteria</b>	3 capsules Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Zovia 1/35E (28)

---

### Products Affected

- ZOVIA 1/35E (28)

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Zovia 1/50E (28)

---

### Products Affected

- ZOVIA 1/50E (28)

<b>QL Criteria</b>	1.5 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zubsolv

---

## Products Affected

- ZUBSOLV SUBLINGUAL TABLET  
SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG

<b>QL Criteria</b>	90 tab Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zubsolv

## Products Affected

- ZUBSOLV SUBLINGUAL TABLET  
SUBLINGUAL 2.9-0.71 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>QL Criteria</b>	3 tablets Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zubsolv

---

## Products Affected

- ZUBSOLV SUBLINGUAL TABLET  
SUBLINGUAL 8.6-2.1 MG

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zubsolv

## Products Affected

- ZUBSOLV SUBLINGUAL TABLET  
SUBLINGUAL 11.4-2.9 MG

PA Criteria	Criteria Details
<b>Covered Uses</b>	Opioid dependence
<b>Exclusion Criteria</b>	Medical literature does not support the concurrent use of opioids/Tramadol as part of opioid drug dependence treatment. Abstinence of opioids/Tramadol is required both during and following therapy with Suboxone/Subutex/Zubsolv/Bunavail/buprenorphine, and will only be covered when determined to be medically necessary (defined as short-term use during and following opioid dependence treatment for the treatment of acute pain related to surgery, dental procedure, or an emergency situation or for long-term use following opioid dependence treatment for the treatment of chronic pain. For long term use, the member must be treated by a single provider of their choice, opioids will only be covered when prescribed by this single provider, and this single provider is aware of past buprenorphine use for opioid dependence treatment in which an opioid dependence diagnosis). Physicians can contact (855) 746-0013 with any information related to the medical necessity for opioid/Tramadol therapy.
<b>Required Medical Information</b>	Prescriber provides verbal verification of patient's current and ongoing enrollment in an outpatient drug addiction treatment program/ counseling. If the member is currently enrolled, the approval will be 6 months. If the member is NOT enrolled (answer=no) and prescriber provides verbal verification of patient's agreed commitment to become enrolled in an acceptable drug addiction treatment program counseling, the approval will be for 2 months (Note: 1 time approval ONLY). If after 2 months member does not enroll in a program, then all future requests will be denied until member enrolls in a program.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	6 months= current enrollment

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days) or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at <a href="http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx">http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx</a>. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).</p>
<b>QL Criteria</b>	1 tablet Per 1 Day
<b>Notes/References</b>	
<b>Revision Date</b>	Prior Authorization: November 30, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zuplenz

---

## Products Affected

- ZUPLENZ

<b>QL Criteria</b>	12 pack Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyban

---

## Products Affected

- ZYBAN

<b>QL Criteria</b>	2 tablets Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zyclara

---

## Products Affected

- ZYCLARA

<b>QL Criteria</b>	56 EA Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyclara Pump

---

## Products Affected

- ZYCLARA PUMP EXTERNAL CREAM 2.5  
%

<b>QL Criteria</b>	2 bottle Per 365 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zyclara Pump

---

## Products Affected

- ZYCLARA PUMP EXTERNAL CREAM 3.75  
%

<b>QL Criteria</b>	56 packets Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zylet

---

## Products Affected

- ZYLET

<b>QL Criteria</b>	1 pen Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# Zymaxid

---

## Products Affected

- ZYMAXID

<b>QL Criteria</b>	6 bottle Per 30 Days
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZyPREXA

---

## Products Affected

- ZYPREXA ORAL TABLET 15 MG, 5 MG, 7.5 MG, 10 MG, 20 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZyPREXA

---

## Products Affected

- ZYPREXA ORAL TABLET 2.5 MG

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	2 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

# ZyPREXA Zydis

---

## Products Affected

- ZYPREXA ZYDIS

<b>ST Criteria</b>	Trial of 1 month each of 1 generic (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) Plus Latuda (NSO)
<b>QL Criteria</b>	1 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015



# Zytiga

---

## Products Affected

- ZYTIGA

<b>QL Criteria</b>	4 tab Per 1 Day
<b>Notes/ References</b>	
<b>Revision Date</b>	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

## Index

ABILIFY DISCMELT .....	3	AFINITOR DISPERZ .....	51
ABILIFY MAINTENA .....	4	AFREZZA .....	52
ABILIFY ORAL SOLUTION .....	2	AGAMATRIX AMP TEST .....	53
ABILIFY ORAL TABLET .....	1	AGAMATRIX JAZZ TEST .....	54
ABSORICA .....	5	AGAMATRIX KEYNOTE TEST .....	55
ABSTRAL .....	6	AGAMATRIX PRESTO TEST .....	56
ACANYA .....	8	AKYNZEO .....	57
ACCU-CHEK ACTIVE .....	9	<i>albertsons test</i> .....	58
ACCU-CHEK AVIVA IN VITRO STRIP .....	10	ALDARA .....	59
ACCU-CHEK AVIVA PLUS IN VITRO .....	11	<i>alendronate sodium oral tablet 35 mg, 70 mg</i> .....	60
ACCU-CHEK COMFORT CURVE IN VITRO STRIP .....	12	<i>alendronate sodium oral tablet 5 mg, 40 mg, 10 mg</i> .....	61
ACCU-CHEK COMPACT .....	13	<i>alfuzosin hcl er</i> .....	62
ACCU-CHEK COMPACT PLUS .....	14	<i>almotriptan malate</i> .....	63
ACCU-CHEK COMPACT TEST DRUM .....	15	ALORA .....	64
ACCU-CHEK SMARTVIEW .....	16	<i>alprazolam er</i> .....	65
ACCUTREND GLUCOSE .....	17	<i>alprazolam xr</i> .....	66
ACIPHEX .....	18	ALSUMA .....	67
ACIPHEX SPRINKLE .....	21	ALTAVERA .....	68
ACTIQ BUCCAL LOLLIPOP 1600 MCG, 800 MCG, 1200 MCG, 400 MCG, 600 MCG .....	22	ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR* 20 MG, 60 MG .....	69
ACTIVELLA .....	24	ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HR* 40 MG .....	70
ACTONEL ORAL TABLET 150 MG .....	25	ALVESCO .....	71
ACTONEL ORAL TABLET 35 MG .....	26	<i>alyacen 1/35</i> .....	72
ACTONEL ORAL TABLET 5 MG, 30 MG .....	27	<i>alyacen 7/7/7</i> .....	73
ACTOPLUS MET .....	28	AMBIEN CR .....	76
ACTOPLUS MET XR .....	29	AMBIEN ORAL TABLET 10 MG .....	74
ACTOS .....	30	AMBIEN ORAL TABLET 5 MG .....	75
ACULAR .....	31	AMERGE .....	77
ACULAR LS .....	32	AMETHIA .....	78
ACURA BLOOD GLUCOSE TEST .....	33	AMETHIA LO .....	79
ACUVAIL .....	34	AMITIZA .....	80
ADCIRCA .....	35	<i>amlodipine besylate-valsartan</i> .....	81
ADDERALL ORAL TABLET 20 MG .....	36	AMNESTEEM .....	82
ADDERALL ORAL TABLET 30 MG, 7.5 MG, 10 MG, 12.5 MG, 15 MG, 5 MG .....	37	<i>amphetamine-dextroamphet er</i> .....	83
ADDERALL XR .....	38	<i>amphetamine-dextroamphetamine oral tablet 20 mg</i> .....	84
ADEMPAS .....	39	<i>amphetamine-dextroamphetamine oral tablet 30 mg, 15 mg, 7.5 mg, 10 mg, 12.5 mg, 5 mg</i> .....	85
ADRENACLICK .....	40	AMPYRA .....	86
ADVAIR DISKUS .....	41	AMRIX .....	87
ADVAIR HFA .....	42	AMTURNIDE .....	88
ADVANCE INTUITION TEST .....	43	ANDRODERM TRANSDERMAL PATCH 24 HR 2 MG/24HR, 4 MG/24HR .....	89
ADVANCE MICRO-DRAW TEST .....	44	ANDROGEL PUMP TRANSDERMAL 12.5 MG/ACT (1%) .....	93
ADVICOR .....	45	ANDROGEL PUMP TRANSDERMAL 20.25 MG/ACT (1.62%) .....	94
ADVOCATE REDI-CODE IN VITRO .....	46		
ADVOCATE REDI-CODE+ TEST .....	47		
ADVOCATE TEST .....	48		
AEROSPAN .....	49		
AFINITOR .....	50		

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

ANDROGEL TRANSDERMAL 20.25 MG/1.25GM (1.62%)	90	AVALIDE ORAL TABLET 300-12.5 MG	134
ANDROGEL TRANSDERMAL 25 MG/2.5GM (1%)	92	AVAPRO ORAL TABLET 300 MG	136
ANDROGEL TRANSDERMAL 40.5 MG/2.5GM (1.62%), 50 MG/5GM (1%)	91	AVAPRO ORAL TABLET 75 MG, 150 MG	135
ANGELIQ	95	AVIANE	137
ANGELIQ	96	<i>avidoxy</i>	138
ANORO ELLIPTA	97	AVINZA	139
ANTARA	98	AVODART	141
<i>antibiotic ear</i>	99	AXERT	142
ANZEMET ORAL	100	AXIRON	143
<i>apap-caff-dihydrocodeine oral capsule</i>	101	AZASITE	144
APLENZIN	102	AZILECT	145
APRI	103	AZOR	146
APRISO	104	AZULFIDINE	147
APTENSIO XR	105	AZULFIDINE EN-TABS	148
APTIOM ORAL TABLET 600 MG	107	AZURETTE	149
APTIOM ORAL TABLET 800 MG, 400 MG, 200 MG	106	<i>balsalazide disodium</i>	150
ARALEN	108	BALZIVA	151
ARANELLE	109	BANZEL ORAL TABLET	152
ARCAPTA NEOHALER	110	BAYER CONTOUR NEXT TEST	153
ARICEPT	111	BAYER CONTOUR TEST	154
ARICEPT ODT	112	BD TEST	155
<i>aripiprazole oral solution</i>	114	BECONASE AQ	156
<i>aripiprazole oral tablet</i>	113	BELSOMRA	157
<i>aripiprazole oral tablet dispersible</i>	113	BENICAR HCT ORAL TABLET 20-12.5 MG	161
ARNUITY ELLIPTA	115	BENICAR HCT ORAL TABLET 40-25 MG, 40-12.5 MG	160
ASACOL HD	116	BENICAR ORAL TABLET 20 MG, 5 MG	158
ASSURE 3 TEST	117	BENICAR ORAL TABLET 40 MG	159
ASSURE 4 TEST	118	BENZAMYCIN	162
ASSURE II	119	BENZAMYCINPAK	163
ASSURE II CHECK	120	BG STAR TEST	164
ASSURE PLATINUM	121	<i>bicalutamide</i>	165
ASSURE PRO TEST	122	<i>bimatoprost ophthalmic</i>	166
AT LAST TEST	123	BINOSTO	167
ATACAND HCT ORAL TABLET 16-12.5 MG	125	BIOSCANNER GLUCOSE TEST	168
ATACAND HCT ORAL TABLET 32-12.5 MG, 32-25 MG	126	<i>bl test strip pack</i>	169
ATACAND ORAL TABLET 8 MG, 16 MG, 4 MG	124	BLEPHAMIDE	170
ATELVIA	127	<i>blood glucose test</i>	171
<i>atorvastatin calcium oral</i>	128	BONIVA ORAL	172
<i>atovaquone-proguanil hcl oral tablet 250-100 mg</i>	129	BREO ELLIPTA INHALATION AEROSOL POWDER, BREATH ACTIVATED 100-25 MCG/INH	174
ATRALIN	130	BREO ELLIPTA INHALATION AEROSOL POWDER, BREATH ACTIVATED 200-25 MCG/INH	173
AUBAGIO	131	<i>briellyn</i>	175
AUBRA	132	BRILINTA	176
AVALIDE ORAL TABLET 150-12.5 MG	133	BRILINTA	177
		BRINTELLIX	178
		BROVANA	179

BUDEPRION SR	180	CESAMET	221
BUDEPRION XL	181	CESIA	222
<i>budesonide er</i>	183	CHANTIX	223
<i>budesonide inhalation suspension 1 mg/2ml</i>	182	CHANTIX CONTINUING MONTH PAK	224
BUNAVAIL BUCCAL FILM 2.1-0.3 MG	185	CHANTIX STARTING MONTH PAK	225
BUNAVAIL BUCCAL FILM 4.2-0.7 MG	186	CHATEAL	226
BUNAVAIL BUCCAL FILM 6.3-1 MG	184	<i>chloroquine phosphate oral</i>	227
<i>buprenorphine hcl sublingual tablet sublingual 2 mg</i>	187	CHOICE DM FORA G20 TEST STRIPS	228
<i>buprenorphine hcl sublingual tablet sublingual 8 mg</i>	188	CICLODAN EXTERNAL SOLUTION	229
<i>buprenorphine hcl-naloxone hcl</i>	189	<i>ciclopirox external solution</i>	230
<i>bupropion hcl er (smoking det)</i>	191	CILOXAN OPHTHALMIC SOLUTION	231
<i>bupropion hcl er (sr)</i>	192	CIPRO HC	233
<i>bupropion hcl er (xl)</i>	193	CIPRO ORAL SUSPENSION RECONSTITUTED	232
<i>bupropion hcl oral</i>	190	CIPRO ORAL TABLET 500 MG, 250 MG	232
<i>butorphanol tartrate nasal</i>	194	CIPRO XR	234
BUTRANS TRANSDERMAL PATCH WEEKLY 5 MCG/HR, 10 MCG/HR, 15 MCG/HR, 20 MCG/HR	195	CIPRODEX	235
BUTRANS TRANSDERMAL PATCH WEEKLY 7.5 MCG/HR	196	<i>ciprofloxacin hcl ophthalmic</i>	236
BYDUREON	197	<i>ciprofloxacin hcl oral</i>	237
BYDUREON	198	<i>ciprofloxacin-ciproflox hcl er</i>	238
BYETTA 10 MCG PEN	199	<i>citalopram hydrobromide oral tablet</i>	239
BYETTA 5 MCG PEN	200	CLARAVIS	240
<i>calcitonin (salmon)</i>	201	CLARINEX ORAL SYRUP	243
CAMBIA	202	CLARINEX ORAL TABLET	241
CAMILA	203	CLARINEX REDITABS	245
CAMRESE	204	CLARINEX-D 12 HOUR	247
CAMRESE LO	205	CLARINEX-D 24 HOUR	249
CANASA	206	CLEVER CHEK AUTO-CODE TEST	251
<i>candesartan cilexetil oral tablet 8 mg, 4 mg, 16 mg</i>	207	CLEVER CHEK AUTO-CODE VOICE IN VITRO	252
<i>candesartan cilexetil-hctz oral tablet 16-12.5 mg</i>	208	CLEVER CHEK TEST	253
CAPRELSA	209	CLEVER CHOICE AUTO-CODE TEST	254
CAREONE BLOOD GLUCOSE TEST	210	CLEVER CHOICE MICRO TEST	255
CARESENS N GLUCOSE TEST	211	CLIMARA	256
CASODEX	212	CLIMARA PRO	257
CAZANT	213	CLOBEX	258
CELEBREX ORAL CAPSULE 200 MG	214	<i>clonidine hcl er</i>	259
CELEBREX ORAL CAPSULE 50 MG, 400 MG, 100 MG	215	<i>clopidogrel bisulfate oral tablet 75 mg</i>	260
<i>celecoxib oral capsule 200 mg</i>	217	<i>clozapine oral tablet 100 mg</i>	263
<i>celecoxib oral capsule 400 mg, 100 mg, 50 mg</i>	216	<i>clozapine oral tablet 200 mg</i>	262
CELEXA	218	<i>clozapine oral tablet 25 mg, 50 mg</i>	261
CENESTIN ORAL TABLET 0.45 MG, 0.625 MG, 0.3 MG, 0.9 MG	219	<i>clozapine oral tablet dispersible 150 mg</i>	264
CERDELGA	220	<i>clozapine oral tablet dispersible 200 mg</i>	262
		CLOZARIL ORAL TABLET 100 MG	265
		CLOZARIL ORAL TABLET 25 MG	266
		COARTEM	267
		COLAZAL	268
		COLCRYS	269
		COLY-MYCIN S	270
		COMBIPATCH	271
		COMBIVIR	272

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

COMETRIQ (100 MG DAILY DOSE).....	273	<i>dextroamphetamine sulfate oral tablet</i> .....	317
COMETRIQ (140 MG DAILY DOSE).....	274	<i>diabetic.com test</i> .....	320
COMETRIQ (60 MG DAILY DOSE).....	275	DIASTAT ACUDIAL.....	321
CONCERTA ORAL TABLET		DIASTAT PEDIATRIC.....	322
EXTENDEDRELEASE* 18 MG, 27 MG, 54 MG		<i>diatrue plus test</i> .....	323
.....	276	DICLEGIS.....	324
CONCERTA ORAL TABLET		<i>diclofenac sodium ophthalmic</i> .....	325
EXTENDEDRELEASE* 36 MG.....	277	DIFFERIN EXTERNAL 0.1 %.....	326
CONTROL AST.....	278	DIFFERIN EXTERNAL CREAM.....	326
CONTROL TEST.....	279	DIFFERIN EXTERNAL LOTION.....	326
CONZIP.....	280	DIFICID.....	327
CORLANOR.....	281	DIFLUCAN ORAL SUSPENSION	
CORTISPORIN OTIC.....	282	RECONSTITUTED.....	328
CORTISPORIN-TC.....	283	DIFLUCAN ORAL TABLET 100 MG, 50 MG,	
COZAAR ORAL TABLET 25 MG, 50 MG.....	284	200 MG.....	328
CRESTOR.....	286	DIOVAN HCT ORAL TABLET 160-25 MG,	
CRYSSELLE-28.....	287	160-12.5 MG, 80-12.5 MG.....	331
CUTIVATE.....	288	DIOVAN HCT ORAL TABLET 320-12.5 MG,	
<i>cvs blood glucose test</i> .....	289	320-25 MG.....	332
CYCLAFEM 1/35.....	290	DIOVAN ORAL TABLET 160 MG, 80 MG, 40	
CYCLAFEM 7/7/7.....	291	MG.....	330
CYMBALTA ORAL CAPSULE DELAYED		DIPENTUM.....	333
RELEASE PARTICLES 30 MG, 20 MG.....	292	<i>discount drug mart test</i> .....	334
CYMBALTA ORAL CAPSULE DELAYED		DITROPAN XL.....	335
RELEASE PARTICLES 60 MG.....	293	DOLOPHINE ORAL TABLET 5 MG.....	336
DAKLINZA.....	294	DORYX.....	337
DARAPRIM.....	295	<i>doxycycline hyclate oral tablet delayed release</i>	
DASETTA 1/35.....	296	.....	338
DASETTA 7/7/7.....	297	<i>doxycycline monohydrate</i> .....	339
DAYSEE.....	298	<i>doxycycline monohydrate</i> .....	340
DAYTRANA.....	299	<i>dronabinol</i> .....	342
DELZICOL.....	300	<i>drospirenone-ethinyl estradiol oral tablet 3-0.03</i>	
<i>demeclocycline hcl oral</i> .....	301	<i>mg</i> .....	343
DEPO-PROVERA INTRAMUSCULAR*		<i>drug emporium test</i> .....	344
SUSPENSION 150 MG/ML.....	302	DUAC.....	345
DEPO-SUBQ PROVERA 104.....	303	<i>duane reade test</i> .....	346
<i>desloratadine</i> .....	304	DUAVEE.....	347
<i>desogestrel-ethinyl estradiol</i> .....	306	DUETACT.....	348
DESONATE.....	307	DUEXIS.....	349
DESOXYN.....	308	DULERA.....	350
DETROL.....	309	<i>duloxetine hcl oral capsule delayed release</i>	
DETROL LA.....	310	<i>particles 20 mg, 30 mg</i> .....	352
DEXEDRINE ORAL CAPSULE EXTENDED		<i>duloxetine hcl oral capsule delayed release</i>	
RELEASE 24 HOUR.....	312	<i>particles 40 mg</i> .....	353
DEXEDRINE ORAL TABLET.....	311	<i>duloxetine hcl oral capsule delayed release</i>	
DEXILANT.....	313	<i>particles 60 mg</i> .....	351
<i>dexmethylphenidate hcl</i> .....	314	DUO-CARE TEST.....	354
<i>dexmethylphenidate hcl er</i> .....	315	DURAGESIC-100.....	355
<i>dexmethylphenidate hcl er</i> .....	316	DURAGESIC-12.....	356
<i>dextroamphetamine sulfate er</i> .....	319	DURAGESIC-25.....	357
<i>dextroamphetamine sulfate oral solution</i> .....	318	DURAGESIC-50.....	358

DURAGESIC-75 .....	359	EQL TRUETEST TEST .....	409
<i>dutasteride</i> .....	360	EQL TRUETRACK TEST .....	410
<i>easy plus blood glucose test</i> .....	361	ERIVEDGE .....	411
<i>easy plus ii glucose test</i> .....	362	ERRIN .....	412
EASY STEP TEST .....	363	ESBRIET .....	413
<i>easy talk blood glucose test</i> .....	364	<i>escitalopram oxalate oral solution</i> .....	415
EASY TOUCH TEST .....	365	<i>escitalopram oxalate oral tablet</i> .....	414
<i>easy trak blood glucose test</i> .....	366	<i>esomeprazole magnesium</i> .....	416
EASYGLUCO IN VITRO .....	367	<i>esomeprazole strontium oral capsule delayed</i>	
EASYMAX 15 TEST .....	368	<i>release 49.3 mg</i> .....	417
EASYMAX TEST .....	369	ESTARYLLA .....	420
<i>easyplus blood glucose test</i> .....	370	<i>estradiol transdermal patch weekly</i> .....	421
EASYPRO BLOOD GLUCOSE TEST .....	371	ESTRASORB .....	422
EASYPRO PLUS IN VITRO .....	372	ESTROGEL .....	423
ECLIPSE TEST .....	373	ESTROSTEP FE .....	424
EDARBI .....	374	<i>eszopiclone</i> .....	425
EDARBYCLOR .....	375	EVAMIST .....	426
EDLUAR .....	376	EVEKEO .....	427
EFFEXOR XR ORAL CAPSULE EXTENDED		EVENCARE + BLOOD GLUCOSE TEST .....	428
RELEASE 24 HOUR 150 MG .....	378	EVENCARE BLOOD GLUCOSE TEST .....	429
EFFEXOR XR ORAL CAPSULE EXTENDED		EVENCARE G2 TEST .....	430
RELEASE 24 HOUR 75 MG, 37.5 MG .....	377	EVENCARE G3 TEST .....	431
EFFIENT .....	379	EVOLUTION AUTOCODE IN VITRO .....	432
<i>element compact test</i> .....	380	EVZIO .....	433
ELEMENT PLUS TEST .....	381	EXACTECH R-S-G TEST .....	434
ELEMENT TEST .....	382	EXACTECH TEST .....	435
ELESTRIN .....	383	EXALGO ORAL 16 MG .....	437
ELIDEL .....	384	EXALGO ORAL 32 MG .....	438
ELINEST .....	385	EXALGO ORAL 8 MG, 12 MG .....	436
ELIQUIS .....	386	EXFORGE .....	439
ELLA .....	387	EXFORGE HCT .....	440
ELMIRON .....	388	<i>express med test strip pack</i> .....	441
EMBEDA .....	389	EZ SMART BLOOD GLUCOSE TEST .....	442
EMBRACE BLOOD GLUCOSE TEST .....	391	EZ SMART PLUS GLUCOSE TEST .....	443
EMBRACE EVO BLOOD GLUCOSE TEST .....	392	FABIOR .....	444
EMBRACE PRO GLUCOSE TEST .....	393	FACTIVE .....	445
EMEND ORAL CAPSULE 125 MG, 40 MG ...	394	FALMINA .....	446
EMEND ORAL CAPSULE 80 & 125 MG .....	396	<i>famciclovir oral tablet 125 mg, 250 mg</i> .....	448
EMEND ORAL CAPSULE 80 MG .....	395	<i>famciclovir oral tablet 500 mg</i> .....	447
EMOQUETTE .....	397	FAMVIR ORAL TABLET 125 MG, 250 MG ...	450
EMSAM .....	398	FAMVIR ORAL TABLET 500 MG .....	449
ENABLEX .....	399	FANAPT .....	451
ENCARE .....	400	FANAPT TITRATION PACK .....	452
ENJUVA .....	401	FARXIGA .....	453
ENPRESSE-28 .....	402	FARYDAK .....	454
ENSKYCE .....	403	FASTTAKE TEST .....	455
<i>entecavir</i> .....	404	FAZACLO ORAL TABLET DISPERSIBLE 100	
ENTOCORT EC .....	405	MG .....	458
ENTRESTO .....	406	FAZACLO ORAL TABLET DISPERSIBLE 12.5	
ENVISION AUTOCODE TEST .....	407	MG .....	456
EPANED .....	408		

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

FAZACLO ORAL TABLET DISPERSIBLE 150 MG	459	FORA V12 BLOOD GLUCOSE TEST	506
FAZACLO ORAL TABLET DISPERSIBLE 200 MG	457	FORA V20 BLOOD GLUCOSE TEST	507
FAZACLO ORAL TABLET DISPERSIBLE 25 MG	460	FORA V22 BLOOD GLUCOSE TEST	508
FC FEMALE CONDOM	461	FORA V30A BLOOD GLUCOSE TEST	509
FC2 FEMALE CONDOM	462	FORACARE GD40 TEST	510
FEMCAP	463	FORACARE PREMIUM V10 TEST	511
FEMHRT LOW DOSE	464	FORACARE TEST N GO TEST	512
FEMRING	465	FORADIL AEROLIZER	513
FENOGLIDE	466	FORFIVO XL	514
<i>fentanyl</i>	467	FORTESTA	515
<i>fentanyl</i>	468	FOSAMAX	516
<i>fentanyl citrate buccal</i>	469	FOSAMAX PLUS D	517
FENTORA	471	FRAGMIN SUBCUTANEOUS* SOLUTION	
FETZIMA	473	95000 UNIT/3.8ML	518
FETZIMA TITRATION	474	FREESTYLE INSULINX TEST	519
FIBRICOR	475	FREESTYLE LITE TEST	520
FIFTY50 GLUCOSE TEST 2.0	476	FREESTYLE TEST	521
FLECTOR	477	FROVA	522
<i>fluconazole oral suspension reconstituted</i>	478	FULYZAQ	523
<i>fluconazole oral tablet 200 mg, 100 mg, 50 mg</i>	478	FYCOMPA	524
<i>fluoxetine hcl oral capsule 10 mg</i>	484	<i>gabapentin oral capsule</i>	526
<i>fluoxetine hcl oral capsule 20 mg</i>	486	<i>gabapentin oral solution</i>	525
<i>fluoxetine hcl oral capsule 40 mg</i>	480	<i>gabapentin oral tablet</i>	527
<i>fluoxetine hcl oral capsule delayed release</i>	481	GABITRIL ORAL TABLET 12 MG, 4 MG	529
<i>fluoxetine hcl oral solution</i>	483	GABITRIL ORAL TABLET 16 MG	528
<i>fluoxetine hcl oral tablet 10 mg, 60 mg</i>	482	GABITRIL ORAL TABLET 2 MG	530
<i>fluoxetine hcl oral tablet 20 mg</i>	485	GARAMYCIN OPHTHALMIC SOLUTION	531
<i>flurbiprofen sodium</i>	487	<i>gatifloxacin</i>	532
<i>fluvastatin sodium</i>	488	<i>ge100 blood glucose test</i>	533
<i>fluvastatin sodium er</i>	489	GELNIQUE	534
<i>fluvoxamine maleate er</i>	492	<i>gentamicin sulfate ophthalmic solution</i>	535
<i>fluvoxamine maleate oral tablet 100 mg</i>	491	GEODON ORAL	536
<i>fluvoxamine maleate oral tablet 25 mg, 50 mg</i>	490	<i>giant eagle pharm test</i>	537
FOCALIN	493	GIANVI	538
FOCALIN XR	494	GIAZO	539
FORA D10 BLOOD GLUCOSE TEST	495	GILDAGIA	540
FORA D15C BLOOD GLUCOSE TEST	496	GILDESS 1.5/30	541
FORA D15G BLOOD GLUCOSE TEST	497	GILDESS 1/20	542
FORA D15Z BLOOD GLUCOSE TEST	498	GILDESS FE 1.5/30	543
FORA D20 BLOOD GLUCOSE TEST	499	GILDESS FE 1/20	544
FORA G20 BLOOD GLUCOSE TEST	500	GILENYA	545
FORA G30A BLOOD GLUCOSE TEST	501	GILOTRIF	546
FORA G71A BLOOD GLUCOSE TEST	502	GLEEVEC	547
FORA G90 BLOOD GLUCOSE TEST	503	GLUCO PERFECT 3 TEST	548
FORA GD20 TEST	504	GLUCOCARD 01 SENSOR PLUS	549
FORA V10 BLOOD GLUCOSE TEST	505	GLUCOCARD EXPRESSION TEST	550
		GLUCOCARD SHINE TEST	551
		GLUCOCARD VITAL TEST	552
		GLUCOCARD X-SENSOR	553
		GLUCOCOM TEST	554
		GLUCOLAB TEST	555

GLUCONAVII BLOOD GLUCOSE TEST	556	IRENKA	599
GLYCATE	557	IRESSA	600
GLYXAMBI	558	<i>itraconazole oral</i>	601
GMATE BLOOD GLUCOSE TEST	559	JAKAFI	603
GRALISE ORAL TABLET 300 MG	561	JALYN	604
GRALISE ORAL TABLET 600 MG	560	JANUMET	605
GRALISE STARTER	562	JANUMET XR ORAL TABLET EXTENDED	
<i>granisetron hcl oral</i>	563	RELEASE 24 HR* 50-1000 MG	607
GRANISOL	564	JANUMET XR ORAL TABLET EXTENDED	
<i>guanfacine hcl er oral tablet extended release 24</i>		RELEASE 24 HR* 50-500 MG, 100-1000 MG	
<i>hr* 1 mg</i>	565		606
HARVONI	566	JANUVIA	608
HEALTH ALLIANCE	567	JARDIANCE	609
HEATHER	568	JENCYCLA	610
HYCAMTIN ORAL	569	JENTADUETO	611
<i>hydroxychloroquine sulfate oral</i>	570	JOLESSA	612
HYSINGLA ER	571	JOLIVETTE	613
HYZAAR ORAL TABLET 100-12.5 MG, 100-25		JUBLIA	614
MG	574	JUNEL 1.5/30	615
HYZAAR ORAL TABLET 50-12.5 MG	573	JUNEL 1/20	616
<i>ibandronate sodium oral</i>	575	JUNEL FE 1.5/30	617
IBRANCE	576	JUNEL FE 1/20	618
ICLUSIG	577	JUXTAPID ORAL CAPSULE 10 MG	622
ILEVRO	578	JUXTAPID ORAL CAPSULE 20 MG	619
IMBRUVICA	579	JUXTAPID ORAL CAPSULE 40 MG, 60 MG, 30	
<i>imiquimod external</i>	580	MG	620
IMITREX NASAL	582	JUXTAPID ORAL CAPSULE 5 MG	621
IMITREX ORAL	583	KADIAN	623
IMITREX SUBCUTANEOUS*	581	KALYDECO	625
IMPLANON	584	KALYDECO	626
INCRUSE ELLIPTA	585	KAPVAY ORAL TABLET EXTENDED	
INFINITY BLOOD GLUCOSE TEST	586	RELEASE 12 HR*	627
INLYTA	587	KARIVA	628
INTERMEZZO SUBLINGUAL TABLET		KAZANO	629
SUBLINGUAL 1.75 MG	588	KELNOR 1/35	630
INTERMEZZO SUBLINGUAL TABLET		KEPPRA XR ORAL TABLET EXTENDED	
SUBLINGUAL 3.5 MG	589	RELEASE 24 HR* 500 MG	631
INTROVALE	590	KEPPRA XR ORAL TABLET EXTENDED	
INTUNIV	591	RELEASE 24 HR* 750 MG	632
INVEGA ORAL TABLET EXTENDED		<i>kerr drug test strip pack</i>	633
RELEASE 24 HR* 3 MG, 1.5 MG, 6 MG	592	<i>ketorolac tromethamine ophthalmic</i>	634
INVEGA ORAL TABLET EXTENDED		<i>ketorolac tromethamine oral</i>	635
RELEASE 24 HR* 9 MG	593	KEVEYIS	636
INVOKAMET ORAL TABLET 150-500 MG,		KHEDEZLA	637
150-1000 MG	595	<i>kinray test</i>	638
INVOKAMET ORAL TABLET 50-1000 MG,		KOMBIGLYZE XR ORAL TABLET	
50-500 MG	594	EXTENDED RELEASE 24 HR* 2.5-1000 MG	
INVOKANA	596		640
<i>irbesartan oral tablet 75 mg, 150 mg</i>	597	KOMBIGLYZE XR ORAL TABLET	
<i>irbesartan-hydrochlorothiazide oral tablet</i>		EXTENDED RELEASE 24 HR* 5-500 MG,	
<i>150-12.5 mg</i>	598	5-1000 MG	639

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)



KORLYM	641	levetiracetam er oral tablet extended release 24 hr* 750 mg	679
<i>  </i> kroger blood glucose test	642	levocetirizine dihydrochloride oral solution	682
<i>  </i> kroger premium glucose test	643	levocetirizine dihydrochloride oral tablet	680
<i>  </i> kroger test	644	levofloxacin oral	684
KURVELO	645	LEVONEST	685
LAMICTAL ODT ORAL TABLET DISPERSIBLE 200 MG, 100 MG	646	levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg, 0.1-0.02 & 0.01 mg	686
LAMICTAL ODT ORAL TABLET DISPERSIBLE 25 MG	648	levonorgestrel oral tablet 0.75 mg	687
LAMICTAL ODT ORAL TABLET DISPERSIBLE 50 MG	647	levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg	688
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 200 MG	649	levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg	689
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 25 MG, 50 MG, 100 MG	651	LEVORA 0.15/30 (28)	690
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HR* 250 MG, 300 MG	650	LEXAPRO ORAL SOLUTION	691
<i>  </i> lamotrigine er oral tablet extended release 24 hr* 100 mg, 25 mg, 50 mg	655	LEXAPRO ORAL TABLET	692
<i>  </i> lamotrigine er oral tablet extended release 24 hr* 200 mg	657	LIALDA	693
<i>  </i> lamotrigine er oral tablet extended release 24 hr* 300 mg, 250 mg	656	LIBERTY NEXT GENERATION TEST	694
<i>  </i> lamotrigine oral tablet dispersible 100 mg, 200 mg	654	<i>  </i> liberty test	695
<i>  </i> lamotrigine oral tablet dispersible 25 mg	652	LIDODERM	696
<i>  </i> lamotrigine oral tablet dispersible 50 mg	653	<i>  </i> life medical test	697
<i>  </i> lansoprazole oral capsule delayed release 30 mg	658	LINZESS	698
LARIN 1/20	659	LIPITOR	699
LARIN FE 1.5/30	660	LIPOFEN	700
LARIN FE 1/20	661	LIPTRUZET	701
<i>  </i> latanoprost ophthalmic	662	LIVALO	702
LATUDA ORAL TABLET 60 MG, 120 MG, 20 MG, 40 MG	663	LOCOID	703
LATUDA ORAL TABLET 80 MG	664	LOCOID LIPOCREAM	704
LAZANDA	665	LOFIBRA	705
LEENA	667	<i>  </i> long test	706
<i>  </i> leflunomide oral	668	LONSURF ORAL TABLET 15-6.14 MG	707
LEMTRADA	669	LONSURF ORAL TABLET 20-8.19 MG	708
LENVIMA 10 MG DAILY DOSE	670	LOPID	709
LENVIMA 14 MG DAILY DOSE	671	LORYNA	710
LENVIMA 20 MG DAILY DOSE	672	<i>  </i> losartan potassium oral tablet 25 mg, 50 mg	711
LENVIMA 24 MG DAILY DOSE	673	<i>  </i> losartan potassium-hctz oral tablet 50-12.5 mg	712
LESCOL	674	LOSEASONIQUE	713
LESCOL XL	675	LOTREL	714
LESSINA	676	LOTRONEX	715
LEVAQUIN ORAL	677	<i>  </i> lovastatin	716
<i>  </i> levetiracetam er oral tablet extended release 24 hr* 500 mg	678	LOVAZA	717
		LOW-OGESTREL	718
		LUMIGAN OPHTHALMIC SOLUTION 0.01 %	719
		LUNESTA	720
		LUTERA	721
		LUVOX CR	722
		LUXIQ	723
		LYNPARZA	724
		LYSTEDA	725

LYZA	726	MIGRANAL	769
MAKENA	727	MIMVEY	770
MALARONE	728	MINIVELLE TRANSDERMAL PATCH	
MARINOL	729	BIWEEKLY 0.025 MG/24HR	772
<i>marlissa</i>	730	MINIVELLE TRANSDERMAL PATCH	
MAXALT	731	BIWEEKLY 0.075 MG/24HR, 0.05 MG/24HR,	
MAXALT-MLT	732	0.0375 MG/24HR, 0.1 MG/24HR	771
MAXIMA BLOOD GLUCOSE TEST	733	<i>minocycline hcl er</i>	773
MAXITROL OPHTHALMIC SUSPENSION	734	MIRAPEX ER	774
<i>medroxyprogesterone acetate intramuscular*</i>	735	MIRENA	775
<i>mefloquine hcl</i>	736	<i>mirtazapine oral tablet 30 mg, 15 mg, 45 mg</i>	776
<i>meijer blood glucose test</i>	737	<i>mirtazapine oral tablet dispersible</i>	776
<i>meijer premium glucose test</i>	738	MIRVASO	777
<i>meijer test</i>	739	MITIGARE	778
MEIJER TRUETEST TEST	740	<i>modafinil</i>	779
MEIJER TRUETRACK TEST	741	MONO-LINYAH	780
MEKINIST	742	MONONESSA	781
MENOSTAR	743	<i>montelukast sodium oral</i>	782
METADATE CD	744	<i>montelukast sodium oral</i>	783
METADATE ER	745	MOVANTIK	784
<i>methadone hcl oral tablet</i>	746	MOXEZA	785
<i>methadone hcl oral tablet soluble</i>	746	MS CONTIN	786
METHADOSE ORAL TABLET	747	MYGLUCOHEALTH TEST	787
METHADOSE ORAL TABLET SOLUBLE	747	MYORISAN ORAL CAPSULE 10 MG, 20 MG,	
<i>methamphetamine hcl</i>	748	40 MG	788
METHYLIN ORAL SOLUTION 10 MG/5ML		MYZILRA	789
	749	<i>naratriptan hcl</i>	790
METHYLIN ORAL SOLUTION 5 MG/5ML	750	NATACYN	791
METHYLIN ORAL TABLET CHEWABLE	751	NATESTO	792
<i>methylphenidate hcl er (cd)</i>	759	NATPARA	793
<i>methylphenidate hcl er (la) oral capsule extended</i>		NAVARRO BLOOD GLUCOSE TEST	794
<i>release 24 hour 20 mg, 40 mg</i>	761	NECON 0.5/35 (28)	795
<i>methylphenidate hcl er (la) oral capsule extended</i>		NECON 1/35 (28)	796
<i>release 24 hour 30 mg</i>	760	NECON 10/11 (28)	797
<i>methylphenidate hcl er oral tablet</i>		NECON 7/7/7	798
<i>extendedrelease* 18 mg, 27 mg, 54 mg</i>	756	<i>neomycin-polymyxin-dexameth ophthalmic</i>	
<i>methylphenidate hcl er oral tablet</i>		<i>suspension 3.5-10000-0.1</i>	799
<i>extendedrelease* 20 mg</i>	757	<i>neomycin-polymyxin-gramicidin</i>	800
<i>methylphenidate hcl er oral tablet</i>		<i>neomycin-polymyxin-hc otic solution 3.5-10000-1</i>	
<i>extendedrelease* 36 mg</i>	758		801
<i>methylphenidate hcl oral solution 10 mg/5ml</i>	752	<i>neomycin-polymyxin-hc otic suspension</i>	802
<i>methylphenidate hcl oral solution 5 mg/5ml</i>	755	NEOSPORIN	803
<i>methylphenidate hcl oral tablet</i>	753	NESINA	804
<i>methylphenidate hcl oral tablet chewable</i>	754	NEUPRO	805
MEVACOR	762	NEURONTIN ORAL CAPSULE	806
MIACALCIN NASAL	763	NEURONTIN ORAL TABLET	807
MICRODOT TEST	764	NEUTEK 2TEK TEST	808
MICROGESTIN 1.5/30	765	NEVANAC	809
MICROGESTIN 1/20	766	NEXAVAR	810
MICROGESTIN FE 1.5/30	767	NEXGEN TEST	811
MICROGESTIN FE 1/20	768	NEXIUM	812

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

NEXIUM	813	<i>olanzapine-fluoxetine hcl</i>	858
NEXPLANON	814	OLUX	859
NICODERM CQ	815	OLUX-E	860
NICORETTE MINI	818	OLYSIO	861
NICORETTE MOUTH/THROAT GUM	816	<i>omega-3-acid ethyl esters</i>	862
NICORETTE MOUTH/THROAT LOZENGE	817	<i>omeprazole oral capsule delayed release</i>	863
	817	<i>omeprazole-sodium bicarbonate oral capsule</i>	
<i>nicotine</i>	819	<i>40-1100 mg</i>	864
<i>nicotine polacrilex mouth/throat gum</i>	821	OMNIFLEX DIAPHRAGM	865
<i>nicotine polacrilex mouth/throat lozenge</i>	820	OMONTYS	866
NICOTROL	822	ON CALL EXPRESS BLOOD GLUCOSE	867
NICOTROL NS	823	ON CALL PLUS BLOOD GLUCOSE	868
NORA-BE	824	ON CALL VIVID BLOOD GLUCOSE	869
<i>norethindrone oral</i>	825	<i>ondansetron</i>	870
<i>norethindrone-eth estradiol oral tablet 0.5-2.5 mg-mcg</i>	826	<i>ondansetron</i>	871
<i>norgestimate-eth estradiol</i>	827	<i>ondansetron hcl oral solution</i>	874
<i>norgestim-eth estrad triphasic</i>	828	<i>ondansetron hcl oral tablet 24 mg</i>	873
<i>norgestrel-ethinyl estradiol</i>	829	<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	872
NOROXIN	830	ONETOUCH TEST	875
NOR-QD	831	ONETOUCH ULTRA BLUE	876
NORTHERA ORAL CAPSULE 100 MG	832	ONETOUCH VERIO IN VITRO STRIP	877
NORTHERA ORAL CAPSULE 200 MG, 300 MG	833	ONEXTON	878
	833	ONFI ORAL TABLET	879
NORTREL 0.5/35 (28)	834	ONGLYZA	880
NORTREL 1/35 (21)	835	ONMEL	881
NORTREL 1/35 (28)	836	OPANA ER ORAL	882
NORTREL 7/7/7	837	OPSUMIT	883
NORVASC	838	OPTIONS CONCEPTROL	884
NOVA MAX GLUCOSE TEST	839	OPTIONS GYNOL II CONTRACEPTIVE	885
NUCYNTA	840	OPTIUM TEST	886
NUCYNTA ER	841	OPTIUMEZ TEST	887
NUEDEXTA	842	OPTUMRX BLOOD GLUCOSE TEST	888
NUVARING	843	ORACEA	889
NUVIGIL ORAL TABLET 150 MG, 250 MG	845	ORAVIG	890
	845	ORKAMBI	891
NUVIGIL ORAL TABLET 200 MG	846	ORSYTHIA	892
NUVIGIL ORAL TABLET 50 MG	844	ORTHO DIAPHRAGM COIL	893
NYMALIZE	847	ORTHO DIAPHRAGM FLAT	894
OCELLA	848	ORTHO EVRA	895
OCUFEN	849	ORTHO MICRONOR	896
OCUFLOX	850	OSENI	897
ODOMZO	851	OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR* 150 MG, 300 MG	898
OFEV	852	OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR* 600 MG	899
<i>ofloxacin ophthalmic</i>	854	<i>oxycodone hcl er</i>	900
<i>ofloxacin oral</i>	853	<i>oxycodone-ibuprofen</i>	901
<i>ofloxacin otic</i>	855	OXYCONTIN	902
<i>olanzapine oral tablet 15 mg, 10 mg, 20 mg, 7.5 mg, 5 mg</i>	856	<i>oxymorphone hcl er</i>	903
<i>olanzapine oral tablet 2.5 mg</i>	857	<i>paliperidone er oral tablet extended release 24 hr*</i>	
<i>olanzapine oral tablet dispersible</i>	856	<i>1.5 mg, 6 mg, 3 mg</i>	904

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

<i>paliperidone er oral tablet extended release 24 hr* 9 mg</i> .....	905	PRECISION PCX PLUS TEST.....	949
<i>pantoprazole sodium oral</i> .....	906	PRECISION POINT OF CARE TEST.....	950
PARAGARD INTRAUTERINE COPPER.....	907	PRECISION QID TEST.....	951
<i>paroxetine hcl er</i> .....	910	PRECISION SOF-TACT TEST.....	952
<i>paroxetine hcl oral tablet 20 mg, 10 mg</i> .....	909	PRECISION XTRA BLOOD GLUCOSE.....	953
<i>paroxetine hcl oral tablet 40 mg, 30 mg</i> .....	908	PRED-G.....	954
PATANOL.....	911	PREFEST.....	955
PAXIL CR.....	915	PRENTIF CAVITY-RIM CERV CAP.....	956
PAXIL ORAL SUSPENSION.....	914	PRENTIF FITTING SET.....	957
PAXIL ORAL TABLET 20 MG, 10 MG.....	913	<i>prestige smart system test</i> .....	958
PAXIL ORAL TABLET 30 MG, 40 MG.....	912	PRESTIGE TEST.....	959
PENLAC.....	916	PRESTIGE VALUE PACK.....	960
PENNSAID TRANSDERMAL SOLUTION 1.5 %.....	917	PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG.....	961
.....	918	PREVACID SOLUTAB.....	964
PENNSAID TRANSDERMAL SOLUTION 2 %.....	918	PREVIFEM.....	967
.....	918	PRILOSEC ORAL CAPSULE DELAYED RELEASE.....	968
PENTASA ORAL CAPSULE EXTENDED RELEASE* 250 MG.....	920	PRILOSEC ORAL PACKET.....	969
PENTASA ORAL CAPSULE EXTENDED RELEASE* 500 MG.....	919	PRISTIQ.....	970
PERFOROMIST.....	921	PRISTIQ.....	971
PERTZYE.....	922	PROAIR HFA.....	972
PEXEVA ORAL TABLET 10 MG, 20 MG.....	923	PROAIR RESPICLICK.....	973
PEXEVA ORAL TABLET 40 MG, 30 MG.....	924	PROCENTRA.....	974
PHARMACIST CHOICE AUTOCODE.....	925	PROCYSBI ORAL CAPSULE DELAYED RELEASE 25 MG.....	975
PHILITH.....	926	PROCYSBI ORAL CAPSULE DELAYED RELEASE 75 MG.....	976
PICATO.....	927	PRODIGY AUTOCODE BLOOD GLUCOSE IN VITRO.....	977
PIMTREA.....	928	PRODIGY NO CODING BLOOD GLUC.....	978
PIRMELLA 1/35.....	929	<i>promethazine hcl oral</i> .....	979
PIRMELLA 7/7/7.....	930	<i>promethazine hcl suppository 25 mg, 12.5 mg</i> .....	979
PLAQUENIL.....	931	<i>promethazine-codeine</i> .....	980
PLAVIX ORAL TABLET 75 MG.....	932	<i>promethazine-dm</i> .....	981
PLEGRIDY.....	933	PROMETHEGAN.....	982
PLEGRIDY STARTER PACK.....	934	PROTONIX ORAL.....	983
POCKETCHEM EZ TEST.....	935	PROTONIX ORAL.....	986
<i>polymyxin b-trimethoprim</i> .....	936	PROTOPIC.....	989
POLYTRIM.....	937	PROVENTIL HFA.....	990
POMALYST.....	938	PROVIGIL.....	991
PORTIA-28.....	939	PROZAC ORAL CAPSULE 10 MG.....	994
POTIGA ORAL TABLET 400 MG, 300 MG, 200 MG.....	940	PROZAC ORAL CAPSULE 20 MG.....	993
POTIGA ORAL TABLET 50 MG.....	941	PROZAC ORAL CAPSULE 40 MG.....	992
PRADAXA.....	942	PROZAC WEEKLY.....	995
PRALUENT.....	943	PTS PANELS GLUCOSE TEST.....	996
<i>pramipexole dihydrochloride er oral tablet extended release 24 hr* 4.5 mg</i> .....	944	PULMICORT FLEXHALER.....	997
PRANDIN.....	945	QUALAQUIN.....	998
PRAVACHOL.....	946	QUASENSE.....	999
<i>pravastatin sodium</i> .....	947	QUDEXY XR.....	1000
PRECISION PCX.....	948		

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

<i>quetiapine fumarate oral tablet 100 mg, 50 mg</i>	1001	REXALL BLOOD GLUCOSE TEST	1041
<i>quetiapine fumarate oral tablet 200 mg</i>	1003	REXULTI	1042
<i>quetiapine fumarate oral tablet 25 mg</i>	1004	RIGHTEST GS100 BLOOD GLUCOSE	1043
<i>quetiapine fumarate oral tablet 300 mg, 400 mg</i>	1002	RIGHTEST GS300 BLOOD GLUCOSE	1044
QUICKTEK TEST	1005	RIGHTEST GS550 BLOOD GLUCOSE	1045
QUILLIVANT XR	1006	RILUTEK	1046
<i>quinine sulfate oral</i>	1007	<i>risedronate sodium oral tablet 150 mg</i>	1049
QUINTET AC BLOOD GLUCOSE TEST	1008	<i>risedronate sodium oral tablet 35 mg</i>	1047
QUINTET BLOOD GLUCOSE TEST	1009	<i>risedronate sodium oral tablet 5 mg, 30 mg</i>	1048
RA TRUETEST TEST	1010	<i>risedronate sodium oral tablet delayed release</i>	1047
<i>rabeprazole sodium</i>	1011	RISPERDAL M-TAB ORAL TABLET DISPERSIBLE 0.5 MG, 1 MG, 2 MG, 3 MG	1052
RANEXA ORAL TABLET EXTENDED RELEASE 12 HR* 1000 MG	1012	RISPERDAL M-TAB ORAL TABLET DISPERSIBLE 4 MG	1053
RANEXA ORAL TABLET EXTENDED RELEASE 12 HR* 500 MG	1013	RISPERDAL ORAL TABLET 3 MG, 2 MG, 0.25 MG, 0.5 MG, 1 MG	1050
RAPAFLO	1014	RISPERDAL ORAL TABLET 4 MG	1051
RAYOS	1015	RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 2 MG, 0.5 MG, 1 MG, 3 MG	1057
RECLAST	1016	RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 4 MG	1056
RECLIPSEN	1017	<i>risperidone oral tablet 0.25 mg, 2 mg, 0.5 mg, 1 mg, 3 mg</i>	1054
REFUAH PLUS BLOOD GLUCOSE TEST	1018	<i>risperidone oral tablet 4 mg</i>	1055
RELENZA DISKHALER	1019	<i>risperidone oral tablet dispersible 0.5 mg, 1 mg, 2 mg, 0.25 mg, 3 mg</i>	1054
RELION BLOOD GLUCOSE TEST	1020	<i>risperidone oral tablet dispersible 4 mg</i>	1055
RELION CONFIRM/MICRO TEST	1021	RITALIN	1058
RELION PRIME TEST	1022	RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 20 MG, 10 MG, 40 MG	1060
RELION ULTIMA TEST	1023	RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 30 MG	1061
RELISTOR SUBCUTANEOUS* KIT	1024	RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 60 MG	1059
RELISTOR SUBCUTANEOUS* SOLUTION 12 MG/0.6ML	1025	RITALIN SR	1062
RELISTOR SUBCUTANEOUS* SOLUTION 8 MG/0.4ML	1026	<i>rizatriptan benzoate</i>	1063
RELPAK	1027	<i>rizatriptan benzoate</i>	1064
REMERON	1028	<i>ropinirole hcl er oral tablet extended release 24 hr* 12 mg</i>	1066
REMERON SOLTAB	1029	<i>ropinirole hcl er oral tablet extended release 24 hr* 2 mg, 6 mg, 8 mg, 4 mg</i>	1065
REPATHA	1030	ROZEREM	1067
REPATHA SURECLICK	1031	SABRIL ORAL PACKET	1068
REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HR* 12 MG	1033	SABRIL ORAL TABLET	1069
REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HR* 8 MG, 4 MG, 6 MG, 2 MG	1032	SANCTURA	1070
RESCULA	1034	SANCUSO	1071
RETIN-A	1035	SAPHRIS	1072
RETIN-A MICRO	1036		
RETIN-A MICRO PUMP EXTERNAL 0.04 %, 0.1 %	1037		
REVATIO ORAL SUSPENSION RECONSTITUTED	1038		
REVATIO ORAL TABLET	1039		
REVEAL BLOOD GLUCOSE TEST	1040		

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

SAPHRIS	1073	SONATA ORAL CAPSULE 10 MG	1118
SAVAYSA	1074	SONATA ORAL CAPSULE 5 MG	1117
SAVELLA	1075	SOVALDI	1119
SAVELLA TITRATION PACK	1076	SPIRIVA HANDIHALER	1120
SEASONIQUE	1077	SPIRIVA RESPIMAT INHALATION AEROSOL, SOLUTION 1.25 MCG/ACT	1121
SEMPREX-D	1078	SPIRIVA RESPIMAT INHALATION AEROSOL, SOLUTION 2.5 MCG/ACT	1122
<i>sentry test</i>	1080	SPORANOX	1123
SEREVENT DISKUS	1081	SPORANOX PULSEPAK	1125
SEROQUEL ORAL TABLET 200 MG	1084	SPRINTEC 28	1127
SEROQUEL ORAL TABLET 25 MG	1083	SPRIX	1128
SEROQUEL ORAL TABLET 300 MG, 400 MG	1085	SPRYCEL	1129
SEROQUEL ORAL TABLET 50 MG, 100 MG	1082	SRONYX	1130
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 200 MG, 150 MG	1087	STIMATE	1131
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 300 MG, 400 MG	1086	STIOLTO RESPIMAT	1132
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 50 MG	1088	STIVARGA	1133
<i>sertraline hcl oral concentrate</i>	1089	STRATTERA ORAL CAPSULE 100 MG, 80 MG	1134
<i>sertraline hcl oral tablet 100 mg</i>	1091	STRATTERA ORAL CAPSULE 40 MG, 60 MG, 25 MG, 10 MG, 18 MG	1135
<i>sertraline hcl oral tablet 25 mg</i>	1092	STRIANT	1136
<i>sertraline hcl oral tablet 50 mg</i>	1090	STRIBILD	1137
<i>shoprite test</i>	1093	STRIVERDI RESPIMAT	1138
SHUR-SEAL CONTRACEPTIVE	1094	SUBOXONE SUBLINGUAL FILM 12-3 MG	1139
SIGNIFOR	1095	SUBOXONE SUBLINGUAL FILM 4-1 MG, 2-0.5 MG, 8-2 MG	1140
SIGNIFOR LAR	1096	SUBOXONE SUBLINGUAL TABLET SUBLINGUAL	1141
<i>sildenafil citrate oral</i>	1097	SUBSYS SUBLINGUAL LIQUID† 100 MCG	1142
SILENOR	1098	SUBSYS SUBLINGUAL LIQUID† 1200 (600 X 2) MCG, 1600 (800 X 2) MCG	1146
SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 500-40 MG, 1000-40 MG	1099	SUBSYS SUBLINGUAL LIQUID† 200 MCG, 600 MCG, 800 MCG, 400 MCG	1144
SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 750-20 MG, 1000-20 MG, 500-20 MG	1100	<i>sulfacetamide sodium ophthalmic solution</i>	1148
SIMPONI	1101	<i>sulfasalazine oral</i>	1149
<i>simvastatin oral</i>	1102	SULFAZINE	1150
SINGULAIR	1103	SULFAZINE EC	1151
SINGULAIR	1104	<i>sumatriptan succinate oral</i>	1152
SIRTURO	1105	SUMAVEL DOSEPRO	1153
SIVEXTRO ORAL	1107	SUMAVEL DOSEPRO	1154
SKELID	1108	SUPREME TEST	1155
SKYLA	1109	SURE EDGE TEST	1156
SMART DIABETES XPRES TEST	1110	SURECHEK BLOOD GLUCOSE TEST	1157
SMART SENSE PREMIUM TEST	1111	SURESTEP PRO TEST	1158
SMART SENSE VALUE TEST	1112	SURESTEP TEST	1159
SMARTEST BLOOD GLUCOSE TEST	1113	SURE-TEST EASYPLUS MINI TEST	1160
SOLIA	1114	SUTENT	1161
SOLODYN	1115	SYEDA	1162
SOLUS V2 TEST	1116		

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)

SYMBICORT .....	1163	<i>topiramate oral capsule sprinkle</i> .....	1208
SYMBYAX .....	1164	TOVIAZ .....	1209
SYMLINPEN 120 .....	1165	TRADJENTA .....	1210
SYMLINPEN 60 .....	1166	<i>tramadol hcl er oral capsule extended release 24</i>	
SYNJARDY .....	1167	<i>hour 100 mg, 300 mg, 200 mg</i> .....	1211
<i>tacrolimus external</i> .....	1168	<i>tranexamic acid oral</i> .....	1212
TAFINLAR .....	1169	TRAVATAN Z .....	1213
TAMIFLU ORAL CAPSULE 45 MG, 30 MG		<i>travoprost</i> .....	1214
.....	1170	<i>tretinoin external</i> .....	1216
TAMIFLU ORAL CAPSULE 75 MG .....	1171	<i>tretinoin external</i> .....	1217
TAMIFLU ORAL SUSPENSION		<i>tretinoin microsphere</i> .....	1218
RECONSTITUTED 6 MG/ML .....	1172	<i>tretinoin microsphere pump</i> .....	1219
TANZEUM .....	1173	<i>tretinoin oral</i> .....	1215
TARCEVA .....	1174	TRETIN-X EXTERNAL CREAM .....	1220
TASIGNA .....	1175	TREXIMET .....	1221
TAZORAC .....	1176	TRIBENZOR .....	1222
TECFIDERA ORAL .....	1177	TRICOR .....	1223
TECFIDERA ORAL CAPSULE DELAYED		TRI-ESTARYLLA .....	1224
RELEASE 120 MG .....	1179	<i>trifluridine ophthalmic</i> .....	1225
TECFIDERA ORAL CAPSULE DELAYED		TRIGLIDE ORAL TABLET 160 MG .....	1226
RELEASE 240 MG .....	1178	TRI-LEGEST FE .....	1227
TECHNIVIE .....	1180	TRI-LINYAH .....	1228
TEKAMLO .....	1181	TRILIPIX .....	1229
TEKTURNA .....	1182	TRINESSA (28) .....	1230
TEKTURNA HCT ORAL TABLET 150-12.5 MG,		TRI-PREVIFEM .....	1231
150-25 MG .....	1183	TRI-SPRINTEC .....	1232
TELCARE BLOOD GLUCOSE TEST .....	1184	TRIVORA (28) .....	1233
TEMODAR ORAL .....	1185	TROKENDI XR ORAL CAPSULE EXTENDED	
<i>temozolomide</i> .....	1186	RELEASE 24 HOUR 100 MG, 25 MG, 50 MG	
TESTIM .....	1187	.....	1234
<i>testosterone transdermal 10 mg/act (2%)</i> .....	1189	TROKENDI XR ORAL CAPSULE EXTENDED	
<i>testosterone transdermal 12.5 mg/act (1%)</i> .....	1191	RELEASE 24 HOUR 200 MG .....	1235
<i>testosterone transdermal 25 mg/2.5gm (1%)</i> .....	1190	<i>true care test strip pack</i> .....	1236
<i>testosterone transdermal 50 mg/5gm (1%)</i> .....	1188	TRUETEST TEST .....	1237
<i>tetrabenazine oral tablet 12.5 mg</i> .....	1193	TRUETRACK TEST .....	1238
<i>tetrabenazine oral tablet 25 mg</i> .....	1192	TRULICITY SUBCUTANEOUS* 1.5 MG/0.5ML	
TEVETEN HCT .....	1195	.....	1239
TEVETEN ORAL TABLET 600 MG .....	1194	TRUVADA .....	1240
<i>tgt blood glucose test</i> .....	1196	TUDORZA PRESSAIR .....	1241
<i>tiagabine hcl oral tablet 2 mg</i> .....	1198	TWINJECT INJECTION 0.15 MG/0.15ML ...	1242
<i>tiagabine hcl oral tablet 4 mg</i> .....	1197	TYKERB .....	1243
TILIA FE .....	1199	UCERIS .....	1244
TIVORBEX .....	1200	UCERIS ORAL .....	1245
TOBRADEX OPHTHALMIC SUSPENSION		ULORIC .....	1246
.....	1201	ULTIMA TEST .....	1247
TOBRADEX ST .....	1202	ULTRATRAK PRO TEST .....	1248
<i>tobramycin ophthalmic</i> .....	1203	ULTRATRAK ULTIMATE TEST .....	1249
<i>tobramycin-dexamethasone</i> .....	1204	ULTRESA .....	1250
TOBREX OPHTHALMIC SOLUTION .....	1205	UNISTRIP1 GENERIC .....	1251
TODAY SPONGE .....	1206	VALCYTE ORAL SOLUTION	
TOPAMAX SPRINKLE .....	1207	RECONSTITUTED .....	1252

VALCYTE ORAL TABLET .....	1253	VYVANSE .....	1296
<i>valganciclovir hcl</i> .....	1254	VYVANSE .....	1297
<i>valsartan-hydrochlorothiazide oral tablet 160-25</i>		WAVESENSE PRESTO .....	1298
<i>mg, 160-12.5 mg, 80-12.5 mg</i> .....	1255	WELLBUTRIN .....	1299
VALTREX .....	1256	WELLBUTRIN SR .....	1300
VASCEPA .....	1257	WELLBUTRIN XL .....	1301
VCF VAGINAL CONTRACEPTIVE VAGINAL		WERA .....	1302
FILM .....	1258	WIDE-SEAL DIAPHRAGM 60 .....	1303
VCF VAGINAL CONTRACEPTIVE VAGINAL		WIDE-SEAL DIAPHRAGM 65 .....	1304
FOAM .....	1258	WIDE-SEAL DIAPHRAGM 70 .....	1305
VECAMYL .....	1259	WIDE-SEAL DIAPHRAGM 75 .....	1306
VELIVET .....	1260	WIDE-SEAL DIAPHRAGM 80 .....	1307
<i>venlafaxine hcl er oral capsule extended release 24</i>		WIDE-SEAL DIAPHRAGM 85 .....	1308
<i>hour 150 mg</i> .....	1267	WIDE-SEAL DIAPHRAGM 90 .....	1309
<i>venlafaxine hcl er oral capsule extended release 24</i>		WIDE-SEAL DIAPHRAGM 95 .....	1310
<i>hour 37.5 mg, 75 mg</i> .....	1266	<i>winn dixie medic test</i> .....	1311
<i>venlafaxine hcl er oral tablet extended release 24</i>		WYMZYA FE .....	1312
<i>hr* 225 mg</i> .....	1265	XALATAN .....	1313
<i>venlafaxine hcl oral tablet 100 mg, 25 mg</i> .....	1261	XALKORI .....	1314
<i>venlafaxine hcl oral tablet 37.5 mg</i> .....	1262	XANAX XR .....	1315
<i>venlafaxine hcl oral tablet 50 mg</i> .....	1263	XARELTO ORAL TABLET 10 MG .....	1318
<i>venlafaxine hcl oral tablet 75 mg</i> .....	1264	XARELTO ORAL TABLET 15 MG .....	1316
VENTOLIN HFA .....	1268	XARELTO ORAL TABLET 20 MG .....	1317
VERDESO .....	1269	XARELTO STARTER PACK .....	1319
VERSACLOZ .....	1270	XELJANZ .....	1320
VESTURA .....	1271	XELODA .....	1321
VIBRAMYCIN .....	1272	XENAZINE ORAL TABLET 12.5 MG .....	1323
VICTORY AGM-4000 TEST .....	1273	XENAZINE ORAL TABLET 25 MG .....	1322
VICTOZA .....	1274	XIFAXAN ORAL TABLET 200 MG .....	1324
VICTRELIS .....	1275	XIFAXAN ORAL TABLET 550 MG .....	1325
VIGAMOX .....	1276	XIGDUO XR .....	1326
VIIBRYD .....	1277	XOPENEX HFA .....	1327
VIIBRYD .....	1278	XTANDI .....	1328
VIIBRYD STARTER PACK .....	1279	XYREM .....	1329
VIMOVO .....	1280	XYZAL ORAL SOLUTION .....	1330
VIMPAT ORAL SOLUTION .....	1281	XYZAL ORAL TABLET .....	1332
VIMPAT ORAL TABLET 150 MG, 100 MG, 200		<i>zaleplon oral capsule 10 mg</i> .....	1334
MG .....	1283	<i>zaleplon oral capsule 5 mg</i> .....	1335
VIMPAT ORAL TABLET 50 MG .....	1282	ZARAH .....	1336
VIOKACE .....	1284	ZECUITY .....	1337
<i>viorele</i> .....	1285	ZEGERID ORAL CAPSULE 40-1100 MG .....	1338
VIRAMUNE .....	1286	ZEGERID ORAL PACKET .....	1341
VIROPTIC .....	1287	ZELAPAR .....	1344
VIVELLE-DOT .....	1288	ZELBORAF .....	1345
VOCAL POINT BLOOD GLUCOSE TEST ..	1289	ZENATANE ORAL CAPSULE 10 MG, 40 MG,	
VOGELXO .....	1290	20 MG .....	1346
VOGELXO PUMP .....	1291	ZENCHENT .....	1347
VOLTAREN TRANSDERMAL .....	1292	ZENCHENT FE .....	1348
VOTRIENT .....	1293	ZENZEDI .....	1349
VYFEMLA .....	1294	ZENZEDI .....	1350
VYTORIN .....	1295	ZEOSA .....	1351

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)



ZERIT .....	1352	ZYPREXA ORAL TABLET 15 MG, 5 MG, 7.5	
ZETIA .....	1353	MG, 10 MG, 20 MG .....	1398
ZETONNA .....	1354	ZYPREXA ORAL TABLET 2.5 MG .....	1399
ZIAGEN .....	1355	ZYPREXA ZYDIS .....	1400
ZIOPTAN .....	1356	ZYTIGA .....	1401
<i>ziprasidone hcl</i> .....	1357		
ZOCOR .....	1358		
ZOFRAN ODT .....	1361		
ZOFRAN ORAL SOLUTION .....	1359		
ZOFRAN ORAL TABLET .....	1360		
ZOHYDRO ER ORAL .....	1362		
<i>zoledronic acid intravenous* concentrate</i> .....	1364		
<i>zoledronic acid intravenous* solution 5 mg/100ml</i>			
.....	1365		
ZOLINZA .....	1366		
<i>zolmitriptan oral</i> .....	1367		
ZOLOFT ORAL CONCENTRATE .....	1369		
ZOLOFT ORAL TABLET 100 MG .....	1368		
ZOLOFT ORAL TABLET 25 MG .....	1371		
ZOLOFT ORAL TABLET 50 MG .....	1370		
<i>zolpidem tartrate er</i> .....	1374		
<i>zolpidem tartrate oral tablet 10 mg</i> .....	1373		
<i>zolpidem tartrate oral tablet 5 mg</i> .....	1372		
ZOLPIMIST .....	1375		
ZOMETA INTRAVENOUS* CONCENTRATE			
.....	1377		
ZOMETA INTRAVENOUS* SOLUTION .....	1376		
ZOMIG NASAL SOLUTION 2.5 MG .....	1378		
ZOMIG NASAL SOLUTION 5 MG .....	1379		
ZOMIG ORAL .....	1380		
ZOMIG ZMT .....	1381		
ZORVOLEX .....	1382		
ZOVIA 1/35E (28) .....	1383		
ZOVIA 1/50E (28) .....	1384		
ZUBSOLV SUBLINGUAL TABLET			
SUBLINGUAL 1.4-0.36 MG, 5.7-1.4 MG .....	1385		
ZUBSOLV SUBLINGUAL TABLET			
SUBLINGUAL 11.4-2.9 MG .....	1389		
ZUBSOLV SUBLINGUAL TABLET			
SUBLINGUAL 2.9-0.71 MG .....	1386		
ZUBSOLV SUBLINGUAL TABLET			
SUBLINGUAL 8.6-2.1 MG .....	1388		
ZUPLENZ .....	1391		
ZYBAN .....	1392		
ZYCLARA .....	1393		
ZYCLARA PUMP EXTERNAL CREAM 2.5 %			
.....	1394		
ZYCLARA PUMP EXTERNAL CREAM 3.75 %			
.....	1395		
ZYLET .....	1396		
ZYMAXID .....	1397		

2015 Aetna Pharmacy Plan Drug List - Premier  
(Updated 12/01/15)