Acamprosate Calcium

Products Affected

- *acamprosate calcium*

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

Accu-Chek Active

Products Affected

- ACCU-CHEK ACTIVE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Aviva

Products Affected

- ACCU-CHEK AVIVA IN VITRO STRIP

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Aviva Plus

Products Affected

- ACCU-CHEK AVIVA PLUS IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Compact Plus

Products Affected

- ACCU-CHEK COMPACT PLUS

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek Compact Test Drum

Products Affected

- ACCU-CHEK COMPACT TEST DRUM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accu-Chek SmartView

Products Affected

- ACCU-CHEK SMARTVIEW

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Accutrend Glucose

Products Affected

- ACCUTREND GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acitretin

Products Affected

- *acitretin*

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

Actemra

Products Affected

- ACTEMRA INTRAVENOUS*

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

Actimmune

Products Affected

- ACTIMMUNE

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

Actoplus met XR

Products Affected

- ACTOPLUS MET XR

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

Acura Blood Glucose Test

Products Affected

- ACURA BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Acuvail

Products Affected

- ACUVAIL

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

Adapalene

Products Affected

- *adapalene external lotion*

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

Adcirca

Products Affected

- ADCIRCA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CV/pulmonaryhypertensionagents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
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

Adefovir Dipivoxil

Products Affected

- *adefovir dipivoxil*

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

Advair Diskus

Products Affected

- ADVAIR DISKUS

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

Advair HFA

Products Affected

- ADVAIR HFA

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

Advance Intuition Meter

Products Affected

- ADVANCE INTUITION METER

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advance Intuition Test

Products Affected

- ADVANCE INTUITION TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advate

Products Affected

- ADVATE

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

Advicor

Products Affected

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

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

Advicor

Products Affected

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

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
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

Advicor

Products Affected

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

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

Advocate Blood Glucose Monitor

Products Affected

- ADVOCATE BLOOD GLUCOSE MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advocate Duo

Products Affected

- ADVOCATE DUO DEVICE

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

Advocate Redi-Code

Products Affected

- ADVOCATE REDI-CODE DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advocate Redi-Code

Products Affected

- ADVOCATE REDI-CODE IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advocate Redi-Code+

Products Affected

- ADVOCATE REDI-CODE+

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advocate Redi-Code+ Test

Products Affected

- ADVOCATE REDI-CODE+ TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Advocate Test

Products Affected

- ADVOCATE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Adynovate

Products Affected

- *adynovate*

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

Afeditab CR

Products Affected

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

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

Afeditab CR

Products Affected

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

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

Afinitor

Products Affected

- AFINITOR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix AMP Test

Products Affected

- AGAMATRIX AMP TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix Jazz Test

Products Affected

- AGAMATRIX JAZZ TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix KeyNote Test

Products Affected

- AGAMATRIX KEYNOTE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix Presto Pro Meter

Products Affected

- AGAMATRIX PRESTO PRO METER

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AgaMatrix Presto Test

Products Affected

- AGAMATRIX PRESTO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Akynzeo

Products Affected

- AKYNZEO

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of nausea and vomiting associated with cancer chemotherapy
Exclusion Criteria	
Required Medical Information	A documented diagnosis of nausea and vomiting associated with cancer chemotherapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 capsules Per 1 month
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: October 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Aldurazyme

Products Affected

- ALDURAZYME

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

Alendronate Sodium

Products Affected

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

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

Alendronate Sodium

Products Affected

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

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

Alfuzosin HCl ER

Products Affected

- *alfuzosin hcl er*

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

Alimta

Products Affected

- ALIMTA

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

Almotriptan Malate

Products Affected

- *almotriptan malate*

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	6 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alogliptin Benzoate

Products Affected

- *alogliptin benzoate*

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

Alogliptin-Metformin HCl

Products Affected

- *alogliptin-metformin hcl*

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

Alogliptin-Pioglitazone

Products Affected

- *alogliptin-pioglitazone*

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

Aloxi

Products Affected

- ALOXI INTRAVENOUS* SOLUTION 0.25 MG/5ML

PA Criteria	Criteria Details
Covered Uses	Prevention of acute or delayed nausea or vomiting associated with initial and repeat courses of moderately and highly emetogenic cancer chemotherapy and prevention of postoperative nausea and vomiting (PONV) for up to 24 hours following surgery
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: May 23, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Alphanate/VWF Complex/Human

Products Affected

- ALPHANATE/VWF COMPLEX/HUMAN

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

AlphaNine SD

Products Affected

- ALPHANINE SD

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

ALPRAZolam ER

Products Affected

- *alprazolam er*

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

ALPRAZolam XR

Products Affected

- *alprazolam xr*

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

Alprolix

Products Affected

- ALPROLIX

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

Altavera

Products Affected

- ALTAVERA

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

Altoprev

Products Affected

- ALTOPREV

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

Alvesco

Products Affected

- ALVESCO

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

Alyacen 1/35

Products Affected

- *alyacen 1/35*

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

Amethia

Products Affected

- AMETHIA

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

Amethia Lo

Products Affected

- AMETHIA LO

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

Amethyst

Products Affected

- AMETHYST

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

Amitiza

Products Affected

- AMITIZA

ST Criteria	Documented step through LACTULOSE OR POLYETHYLENE GLYCOL
QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amlodipine Besylate-Valsartan

Products Affected

- *amlodipine besylate-valsartan*

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

Amnesteem

Products Affected

- AMNESTEEM

ST Criteria	Documented step through MINOCYCLINE OR DOXYCYCLINE
QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Amphetamine Salt Combo

Products Affected

- *amphetamine salt combo*

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

Amphetamine-Dextroamphet ER

Products Affected

- *amphetamine-dextroamphet er*

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

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

Amphetamine-Dextroamphetamine

Products Affected

- *amphetamine-dextroamphetamine*

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

Ampyra

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 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
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	1 patch Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	5 grams-2 packets Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	1 1.25 gm packet Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	1 25 gram packet Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel

Products Affected

- ANDROGEL TRANSDERMAL GEL 50 MG/5GM (1%)

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	2 10 gm packets Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

AndroGel Pump

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	10 grams Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Innovation Health Leap Drug Guide
Last update 12/2016

AndroGel Pump

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	4 pumps Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Anzemet

Products Affected

- ANZEMET ORAL

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

Apidra

Products Affected

- APIDRA

ST Criteria	Documented step through HUMALOG product
QL Criteria	1 SOLN Per 180 FILLs
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Apidra SoloStar

Products Affected

- APIDRA SOLOSTAR SUBCUTANEOUS*

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

Apri

Products Affected

- APRI

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

Apriso

Products Affected

- APRISO

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

Aralast NP

Products Affected

- ARALAST NP

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

Aranelle

Products Affected

- ARANELLE

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

Aranesp (Albumin Free)

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 150 MCG/0.75ML, 10 MCG/0.4ML, 60 MCG/ML, 100 MCG/ML, 200 MCG/ML
- ARANESP (ALBUMIN FREE) INJECTION

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

Aranesp (Albumin Free)

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION

PA Criteria	Criteria Details
Covered Uses	Anemia from myelodysplastic syndrome; or Anemia of prematurity; or Special circumstance members who will not or can not receive whole blood or components as replacement for traumatic or surgical loss; or Treatment of anemic members scheduled to undergo hi
Exclusion Criteria	Non-covered uses include the following-Acute renal injury, Anemia associated only with radiotherapy, Anemia associated with the treatment of acute and chronic myelogenous leukemia (AML, CML) or erythroid cancers, Anemia due to bleeding (other than indicatio
Required Medical Information	A. Treatment of anemia associated with chronic kidney disease (CKD) receiving dialysis: Requirement of laboratory evidence: 1) Initiation hemoglobin (g/dL) is less than 10g/dL and Hemoglobin is not maintained above 11g/dL. Maintenance of Hct > 36% or a
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 months
Other Criteria	1. Regardless of indication, member is experiencing symptomatic anemia, such as fatigue, weakness, shortness of breath, or lightheadedness that are significantly impacting the ability of the patient to perform necessary activities of daily living, Or if
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Arcalyst

Products Affected

- ARCALYST

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

Arcapta Neohaler

Products Affected

- ARCAPTA NEOHALER

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

ARIPiprazole

Products Affected

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

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

ARIPiprazole

Products Affected

- *aripiprazole oral solution*

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

Armodafinil

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	excessive daytime sleepiness, Shift Work Sleep Disorder
Exclusion Criteria	Nuvigil is not indicated to treat side effects caused by other medications.
Required Medical Information	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage), and the patient has failed an adequate trial of at least TWO of the following immediate release stimulants (all available generically): Dexedrine, Ritalin, or Adderall, and the patient has stepped through an adequate trial of modafinil (modafinil requires prior authorization). FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a standard diagnostic nocturnal polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and the patient must be compliant with recommendations for OSAHS treatment, and the patient has stepped through an adequate trial of modafinil (modafinil requires prior authorization).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: The plan also requires an unresponsive 2-week trial of 150mg per day dose before a 250mg per day dose is authorized. (Doses up to 250 mg/day can be used but there is no solid evidence that it provides additional benefit beyond 150 mg/day.)

QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Armodafinil

Products Affected

- *armodafinil oral tablet 50 mg*

PA Criteria	Criteria Details
Covered Uses	excessive daytime sleepiness, Shift Work Sleep Disorder
Exclusion Criteria	Nuvigil is not indicated to treat side effects caused by other medications.
Required Medical Information	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage), and the patient has failed an adequate trial of at least TWO of the following immediate release stimulants (all available generically): Dexedrine, Ritalin, or Adderall, and the patient has stepped through an adequate trial of modafinil (modafinil requires prior authorization). FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA/HYPOPNEA SYNDROME: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a standard diagnostic nocturnal polysomnography (NPSG) has confirmed the diagnosis of OSAHS, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy must be continued on a routine basis in combination with armodafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patients ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSAHS in conjunction with treating the daily fatigue, and the patient must be compliant with recommendations for OSAHS treatment, and the patient has stepped through an adequate trial of modafinil (modafinil requires prior authorization).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: The plan also requires an unresponsive 2-week trial of 150mg per day dose before a 250mg per day dose is authorized. (Doses up to 250 mg/day can be used but there is no solid evidence that it provides additional benefit beyond 150 mg/day.)

QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Arzerra

Products Affected

- ARZERRA

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

Ascensia Autodisc Test

Products Affected

- ASCENSIA AUTODISC TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Asmanex 120 Metered Doses

Products Affected

- ASMANEX 120 METERED DOSES

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

Asmanex 14 Metered Doses

Products Affected

- ASMANEX 14 METERED DOSES

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

Asmanex 30 Metered Doses

Products Affected

- ASMANEX 30 METERED DOSES

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

Asmanex 60 Metered Doses

Products Affected

- ASMANEX 60 METERED DOSES

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

Assure 3 Test

Products Affected

- ASSURE 3 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure 4 Meter

Products Affected

- ASSURE 4 METER

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure 4 Test

Products Affected

- ASSURE 4 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure Platinum

Products Affected

- ASSURE PLATINUM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure Platinum Meter

Products Affected

- ASSURE PLATINUM METER

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure Pro Blood Glucose Meter

Products Affected

- ASSURE PRO BLOOD GLUCOSE METER

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Assure Pro Test

Products Affected

- ASSURE PRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Atorvastatin Calcium

Products Affected

- *atorvastatin calcium oral*

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

Atripla

Products Affected

- ATRIPLA

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

Aubagio

Products Affected

- AUBAGIO

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

Avandamet

Products Affected

- AVANDAMET ORAL TABLET 2-500 MG

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

Avandamet

Products Affected

- AVANDAMET ORAL TABLET 2-1000 MG

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

Avandia

Products Affected

- AVANDIA

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

Aviane

Products Affected

- AVIANE

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

Avita

Products Affected

- AVITA EXTERNAL CREAM

QL Criteria	50 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avonex

Products Affected

- AVONEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
QL Criteria	4 doses Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Avonex Pen

Products Affected

- AVONEX PEN INTRAMUSCULAR*

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

Avonex Prefilled

Products Affected

- AVONEX PREFILLED INTRAMUSCULAR*

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

Axiron

Products Affected

- AXIRON

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	4 pumps Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Azilect

Products Affected

- AZILECT

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

Azor

Products Affected

- AZOR

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

Azurette

Products Affected

- AZURETTE

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

Balsalazide Disodium

Products Affected

- *balsalazide disodium*

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

Balziva

Products Affected

- BALZIVA

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

Banzel

Products Affected

- BANZEL ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment of seizures associated with Lennox-Gastaut syndrome
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Banzel

Products Affected

- BANZEL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment of seizures associated with Lennox-Gastaut syndrome
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Baraclude

Products Affected

- BARACLUDE ORAL TABLET

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

Bayer Breeze 2 Test

Products Affected

- BAYER BREEZE 2 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bayer Contour Monitor

Products Affected

- BAYER CONTOUR MONITOR DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bayer Contour Next Test

Products Affected

- BAYER CONTOUR NEXT TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bayer Contour Test

Products Affected

- BAYER CONTOUR TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bebulin

Products Affected

- BEBULIN

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

Bebulin VH

Products Affected

- BEBULIN VH

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

Beconase AQ

Products Affected

- BECONASE AQ

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

Benicar

Products Affected

- BENICAR

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

Benicar HCT

Products Affected

- BENICAR HCT

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

Benlysta

Products Affected

- BENLYSTA

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

Betaseron

Products Affected

- BETASERON SUBCUTANEOUS* KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
QL Criteria	1 box (15 vials) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bexarotene

Products Affected

- *bexarotene*

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

BG Star Test

Products Affected

- BG STAR TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bicalutamide

Products Affected

- *bicalutamide*

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

Bimatoprost

Products Affected

- *bimatoprost ophthalmic*

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

Bivigam

Products Affected

- BIVIGAM

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

Bosulif

Products Affected

- BOSULIF ORAL TABLET 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 EA Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bosulif

Products Affected

- BOSULIF ORAL TABLET 500 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Botox

Products Affected

- BOTOX

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

Bravelle

Products Affected

- BRAVELLE

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

Breeze 2 Blood Glucose System

Products Affected

- BREEZE 2 BLOOD GLUCOSE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Brevicon (28)

Products Affected

- BREVICON (28)

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

Briellyn

Products Affected

- *briellyn*

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

Brilinta

Products Affected

- BRILINTA

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

Brovana

Products Affected

- BROVANA

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

Budesonide

Products Affected

- *budesonide inhalation*

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

Bunavail

Products Affected

- BUNAVAIL

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

PA Criteria	Criteria Details
Other Criteria	For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
ST Criteria	A documented step through one month each of the preferred alternatives, buprenorphine-naloxone sublingual tablet and Suboxone SL film
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buphenyl

Products Affected

- BUPHENYL ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buprenorphine HCl

Products Affected

- *buprenorphine hcl sublingual tablet sublingual*
  8 mg

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

PA Criteria	Criteria Details
Other Criteria	For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	3 tablets Per 1 Day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buprenorphine HCl

Products Affected

- *buprenorphine hcl sublingual tablet sublingual*
  2 mg

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

PA Criteria	Criteria Details
Other Criteria	For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buprenorphine HCl-Naloxone HCl

Products Affected

- *buprenorphine hcl-naloxone hcl*

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

PA Criteria	Criteria Details
Other Criteria	For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Buproban

Products Affected

- BUPROBAN

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

BuPROPion HCl

Products Affected

- *bupropion hcl oral*

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

BuPROPion HCl ER (Smoking Det)

Products Affected

- *bupropion hcl er (smoking det)*

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

BuPROPion HCl ER (SR)

Products Affected

- *bupropion hcl er (sr)*

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

BuPROPion HCl ER (XL)

Products Affected

- *bupropion hcl er (xl)*

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

Butorphanol Tartrate

Products Affected

- *butorphanol tartrate nasal*

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

Butrans

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	1 box (4 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bydureon

Products Affected

- BYDUREON SUBCUTANEOUS* SUSPENSION RECONSTITUTED

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must an A1C level is greater than 6.5%, have failed to obtain adequate glycemic control on maximum tolerated dose of metformin (unless the patient is not a candidate for metformin therapy) and a second antidiabetic agent (either a sulfonylurea, a thiazolidinedione (TZD), a DPP4-inhibitor or basal insulin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	4 vials Per 1 month
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Byetta 10 MCG Pen

Products Affected

- BYETTA 10 MCG PEN SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must an A1C level is greater than 6.5%, have failed to obtain adequate glycemic control on maximum tolerated dose of metformin (unless the patient is not a candidate for metformin therapy) and a second antidiabetic agent (either a sulfonylurea, a thiazolidinedione (TZD), a DPP4-inhibitor or basal insulin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 pen Per 1 month
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Byetta 5 MCG Pen

Products Affected

- BYETTA 5 MCG PEN SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must an A1C level is greater than 6.5%, have failed to obtain adequate glycemic control on maximum tolerated dose of metformin (unless the patient is not a candidate for metformin therapy) and a second antidiabetic agent (either a sulfonylurea, a thiazolidinedione (TZD), a DPP4-inhibitor or basal insulin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 pen Per 1 month
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Bystolic

Products Affected

- BYSTOLIC ORAL TABLET 20 MG

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

Bystolic

Products Affected

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

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

Calcipotriene

Products Affected

- *calcipotriene external*

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

Calcipotriene-Betameth Diprop

Products Affected

- *calcipotriene-betameth diprop*

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

Calcitonin (Salmon)

Products Affected

- *calcitonin (salmon)*

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 bottle Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Calcitrene

Products Affected

- CALCITRENE

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

Camila

Products Affected

- CAMILA

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

Camrese

Products Affected

- CAMRESE

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

Camrese Lo

Products Affected

- CAMRESE LO

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

Canasa

Products Affected

- CANASA

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

Candesartan Cilexetil

Products Affected

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

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

Candesartan Cilexetil-HCTZ

Products Affected

- *candesartan cilexetil-hctz*

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

Capecitabine

Products Affected

- *capecitabine*

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

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Caprelsa

Products Affected

- CAPRELSA ORAL TABLET 300 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Carbaglu

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cardura XL

Products Affected

- CARDURA XL

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

CareSens N Glucose System

Products Affected

- CARESENS N GLUCOSE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CareSens N Glucose Test

Products Affected

- CARESENS N GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Carimune NF

Products Affected

- CARIMUNE NF INTRAVENOUS* SOLUTION RECONSTITUTED 6 GM, 12 GM

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

Cartia XT

Products Affected

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

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

Cartia XT

Products Affected

- CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG

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

Cayston

Products Affected

- CAYSTON

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

Caziant

Products Affected

- CAZIANT

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

Cefixime

Products Affected

- *cefixime*

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

Celecoxib

Products Affected

- *celecoxib oral*

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

Cerdelga

Products Affected

- CERDELGA

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

Cerezyme

Products Affected

- CEREZYME INTRAVENOUS* SOLUTION RECONSTITUTED 400 UNIT

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

Cesamet

Products Affected

- CESAMET

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

Cesia

Products Affected

- CESIA

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

Cetrotide

Products Affected

- CETROTIDE SUBCUTANEOUS* KIT 0.25 MG

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

Cevimeline HCl

Products Affected

- *cevimeline hcl*

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

Chantix

Products Affected

- CHANTIX

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

Chantix Continuing Month Pak

Products Affected

- CHANTIX CONTINUING MONTH PAK

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

Chantix Starting Month Pak

Products Affected

- CHANTIX STARTING MONTH PAK

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

Chateal

Products Affected

- CHATEAL

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

Chenodal

Products Affected

- CHENODAL

PA Criteria	Criteria Details
Covered Uses	Cholesterol-type gallstones, Cerebrotendinous Xanthomatosis (CTX)
Exclusion Criteria	Intrahepatic duct calculus, Chronic constipation in patients with cholesterol gallstones, Prophylaxis of recurrent gallstones, Hyperlipidemia, Rheumatoid Arthritis
Required Medical Information	For treatment of cholesterol-type gallstones, documentation of trial and failure of 2 years of generic ursodiol therapy, and documentaion of inability to undergo surgery due to systemic disease or age.
Age Restrictions	18 Years of age or greater
Prescriber Restrictions	
Coverage Duration	1 month, extended approval after 3 months based on response and laboratory values
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: April 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Chorionic Gonadotropin

Products Affected

- *chorionic gonadotropin intramuscular**

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

Cialis

Products Affected

- CIALIS ORAL TABLET 5 MG

PA Criteria	Criteria Details
Covered Uses	Benign Prostatic hyperplasia (BPH)
Exclusion Criteria	Use solely for erectile dysfunction.
Required Medical Information	Diagnosis of benign prostatic hyperplasia, a trial and failure of two alpha blockers, and trial and failure of one 5-alpha reductase inhibitor
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 07/2016
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cimzia

Products Affected

- CIMZIA SUBCUTANEOUS* KIT 2 X 200 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cimzia Prefilled

Products Affected

- CIMZIA PREFILLED

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cimzia Starter Kit

Products Affected

- CIMZIA STARTER KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Cimzia.html
QL Criteria	1 kit Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Citalopram Hydrobromide

Products Affected

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

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

Citalopram Hydrobromide

Products Affected

- *citalopram hydrobromide oral tablet 40 mg*

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

Claravis

Products Affected

- CLARAVIS

ST Criteria	Documented step through MINOCYCLINE OR DOXYCYCLINE
QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Auto-Code

Products Affected

- CLEVER CHEK AUTO-CODE

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

Clever Chek Auto-Code System

Products Affected

- CLEVER CHEK AUTO-CODE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Auto-Code Test

Products Affected

- CLEVER CHEK AUTO-CODE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Auto-Code Voice

Products Affected

- CLEVER CHEK AUTO-CODE VOICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Auto-Code Voice

Products Affected

- CLEVER CHEK AUTO-CODE VOICE IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Chek Test

Products Affected

- CLEVER CHEK TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Choice Auto-Code System

Products Affected

- CLEVER CHOICE AUTO-CODE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Choice Auto-Code Test

Products Affected

- CLEVER CHOICE AUTO-CODE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Choice Micro Test

Products Affected

- CLEVER CHOICE MICRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Clever Choice Mini System

Products Affected

- CLEVER CHOICE MINI SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Climara Pro

Products Affected

- CLIMARA PRO

QL Criteria	1 box (4 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

CloNIDine HCl ER

Products Affected

- *clonidine hcl er*

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

Clopidogrel Bisulfate

Products Affected

- *clopidogrel bisulfate*

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

CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

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

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 150 mg, 200 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet dispersible 12.5 mg*

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

CloZAPine

Products Affected

- *clozapine oral tablet 200 mg*

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

Coagadex

Products Affected

- COAGADEX

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

Colchicine

Products Affected

- *colchicine oral tablet*

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

Colyte with Flavor Packs

Products Affected

- COLYTE WITH FLAVOR PACKS ORAL SOLUTION RECONSTITUTED 227.1 GM

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

CombiPatch

Products Affected

- COMBIPATCH

QL Criteria	8 patches Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cometriq (100 mg Daily Dose)

Products Affected

- COMETRIQ (100 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 kits Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cometriq (140 mg Daily Dose)

Products Affected

- COMETRIQ (140 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 EA Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cometriq (60 mg Daily Dose)

Products Affected

- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 kits Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Complera

Products Affected

- COMPLERA

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

Control AST

Products Affected

- CONTROL AST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Control Test

Products Affected

- CONTROL TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Copaxone

Products Affected

- COPAXONE SUBCUTANEOUS* 40 MG/ML

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

Copaxone

Products Affected

- COPAXONE SUBCUTANEOUS* 20 MG/ML

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

Cordran

Products Affected

- CORDRAN EXTERNAL TAPE

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

Coreg CR

Products Affected

- COREG CR

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

Corifact

Products Affected

- CORIFACT

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

Cosopt PF

Products Affected

- COSOPT PF

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

Creon

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	Annual Review: 07/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Crinone

Products Affected

- CRINONE

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

Cryselle-28

Products Affected

- CRYSELLE-28

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

Cuvposa

Products Affected

- CUVPOSA

PA Criteria	Criteria Details
Covered Uses	neurologic conditions associated with drooling (e.g. cerebral palsy)
Exclusion Criteria	
Required Medical Information	Documentaion of neurologic conditions associated with drooling (e.g. cerebral palsy) to reduce severe chronic drooling
Age Restrictions	3 years to 16 years
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Cyclafem 1/35

Products Affected

- CYCLAFEM 1/35

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

Cyclessa

Products Affected

- CYCLESSA

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

Cycloset

Products Affected

- CYCLOSET

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

Dacogen

Products Affected

- DACOGEN

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

Daklinza

Products Affected

- DAKLINZA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Daklinza

Products Affected

- DAKLINZA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
QL Criteria	1 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Daliresp

Products Affected

- DALIRESP

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

Darifenacin Hydrobromide ER

Products Affected

- *darifenacin hydrobromide er*

ST Criteria	Documented step through OXYBUTYNIN or TROSPIUM AND VESICARE or MYRBETRIQ
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

Dasetta 1/35

Products Affected

- DASETTA 1/35

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

Daysee

Products Affected

- DAYSEE

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

Daytrana

Products Affected

- DAYTRANA

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Deblitane

Products Affected

- DEBLITANE

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

Decitabine

Products Affected

- *decitabine*

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

Delzicol

Products Affected

- DELZICOL

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

Denavir

Products Affected

- DENAVIR

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

Depo-Provera

Products Affected

- DEPO-PROVERA INTRAMUSCULAR*
  SUSPENSION 150 MG/ML

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

Depo-SubQ Provera 104

Products Affected

- DEPO-SUBQ PROVERA 104 SUBCUTANEOUS* SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Contraception/hormone therapy
Exclusion Criteria	
Required Medical Information	A documented contraindication or intolerance or allergy or failure of an adequate trial of one month of one preferred oral generic alternative or a documented mental or physical handicap preventing the reasonable use of an oral contraceptive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	1 syringe Per 90 dayss
Notes/ References	Annual Review: 08/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Descovy

Products Affected

- DESCOVY

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

Desloratadine

Products Affected

- *desloratadine*

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

Desogen

Products Affected

- DESOGEN

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

Dexcom G4 Platinum Receiver

Products Affected

- DEXCOM G4 PLATINUM RECEIVER

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

Dexcom G4 Platinum Sensor Kit

Products Affected

- DEXCOM G4 PLATINUM SENSOR KIT

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

Dexcom G4 Platinum Transmitter

Products Affected

- DEXCOM G4 PLATINUM TRANSMITTER

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

Dexcom G4 Sensor

Products Affected

- DEXCOM G4 SENSOR

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

Dexilant

Products Affected

- DEXILANT

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

PA Criteria	Criteria Details
Other Criteria	A step through one of these high dose therapies (80mg/day of Prilosec OTC/omeprazole or pantoprazole, OR 60mg/day of Prevacid 24H OTC) is required even if the member was previously approved for Rabeprazole, Prevacid solutabs, or Nexium at standard dosing. Exceptions may be considered if there is documentation of intolerance, e.g., side-effects or allergies to Prilosec OTC/omeprazole, pantoprazole, and Prevacid 24H OTC.
QL Criteria	1 capsule Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dexmethylphenidate HCl

Products Affected

- *dexmethylphenidate hcl*

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

Dexmethylphenidate HCl ER

Products Affected

- *dexmethylphenidate hcl er*

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral solution*

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

Dextroamphetamine Sulfate

Products Affected

- *dextroamphetamine sulfate oral tablet*

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

Dextroamphetamine Sulfate ER

Products Affected

- *dextroamphetamine sulfate er*

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

Diazepam

Products Affected

- *diazepam gel*

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

Diclofenac Sodium

Products Affected

- *diclofenac sodium transdermal gel 1 %*

QL Criteria	200 grams Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Dificid

Products Affected

- DIFICID

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

Diltiazem CD

Products Affected

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

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

Diltiazem CD

Products Affected

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

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

Diltiazem HCl ER

Products Affected

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

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

Diltiazem HCl ER

Products Affected

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

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

Diltiazem HCl ER Beads

Products Affected

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

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

Diltiazem HCl ER Beads

Products Affected

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

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

Diltiazem HCl ER Coated Beads

Products Affected

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

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

Diltiazem HCl ER Coated Beads

Products Affected

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

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

Dilt-XR

Products Affected

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

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

Dilt-XR

Products Affected

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

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

Dipentum

Products Affected

- DIPENTUM

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

Donepezil HCl

Products Affected

- *donepezil hcl oral tablet 23 mg*

ST Criteria	Documented step through DONEPEZIL 10MG
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Donepezil HCl

Products Affected

- *donepezil hcl oral tablet 10 mg*

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

Dronabinol

Products Affected

- *dronabinol*

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

Drospiren-Eth Estrad-Levomefol

Products Affected

- *drospiren-eth estrad-levomefol*

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

Drospirenone-Ethinyl Estradiol

Products Affected

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

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

Dulera

Products Affected

- DULERA

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

DULoxetine HCl

Products Affected

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

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

DULoxetine HCl

Products Affected

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

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

DULoxetine HCl

Products Affected

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

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

Dutasteride

Products Affected

- *dutasteride*

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

Easy Plus II Glucose System

Products Affected

- *easy plus ii glucose system*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Plus II Glucose Test

Products Affected

- *easy plus ii glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Step Glucose Monitor

Products Affected

- EASY STEP GLUCOSE MONITOR DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Step Test

Products Affected

- EASY STEP TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Talk Blood Glucose System

Products Affected

- *easy talk blood glucose system device*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Talk Blood Glucose Test

Products Affected

- *easy talk blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Touch Test

Products Affected

- EASY TOUCH TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Easy Trak Blood Glucose Test

Products Affected

- *easy trak blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyGluco

Products Affected

- EASYGLUCO IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyMax 15 Test

Products Affected

- EASYMAX 15 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyMax L Blood Glucose

Products Affected

- EASYMAX L BLOOD GLUCOSE DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyMax N Blood Glucose

Products Affected

- EASYMAX N BLOOD GLUCOSE DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyMax NG Blood Glucose

Products Affected

- EASYMAX NG BLOOD GLUCOSE DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EASYMax Test

Products Affected

- EASYMAX TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyMax V Blood Glucose

Products Affected

- EASYMAX V BLOOD GLUCOSE DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyMax V2 Blood Glucose

Products Affected

- EASYMAX V2 BLOOD GLUCOSE DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyPlus Blood Glucose Test

Products Affected

- *easyplus blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EasyPRO Plus

Products Affected

- EASYPRO PLUS IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Edarbi

Products Affected

- EDARBI

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

Edarbyclor

Products Affected

- EDARBYCLOR

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

Edurant

Products Affected

- EDURANT

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

Effient

Products Affected

- EFFIENT

ST Criteria	Documented step through CLOPIDOGREL
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Egrifta

Products Affected

- EGRIFTA SUBCUTANEOUS* SOLUTION RECONSTITUTED 2 MG

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

Elaprase

Products Affected

- ELAPRASE

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

Elelyso

Products Affected

- ELELYSO

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

Element Plus

Products Affected

- ELEMENT PLUS

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Element Test

Products Affected

- ELEMENT TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elidel

Products Affected

- ELIDEL

PA Criteria	Criteria Details
Covered Uses	Atopic Dermatitis
Exclusion Criteria	
Required Medical Information	FOR CHILDREN LESS THAN 2 YEARS OF AGE: Covered for the treatment of mild to moderate atopic dermatitis (eczema) for short-term use (up to 3 months). FOR ADULTS: A documented diagnosis of atopic dermatitis (eczema) and the patient has 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 the patient is being treated for atopic dermatitis (eczema) in an area at high risk for skin atrophy such as face, eyelids, or genital areas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year (3 months if less than 2 years old)
Other Criteria	
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Elinest

Products Affected

- ELINEST

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

Eliquis

Products Affected

- ELIQUIS

ST Criteria	A documented step through Xarelto and Pradaxa
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ella

Products Affected

- ELLA

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

Eloctate

Products Affected

- ELOCTATE

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

Embeda

Products Affected

- EMBEDA

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Embrace Blood Glucose Monitor

Products Affected

- EMBRACE BLOOD GLUCOSE MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Embrace Blood Glucose Test

Products Affected

- EMBRACE BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Emend

Products Affected

- EMEND ORAL CAPSULE 80 & 125 MG

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

Emend

Products Affected

- EMEND ORAL CAPSULE 125 MG, 80 MG, 40 MG

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

Emoquette

Products Affected

- EMOQUETTE

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

Emsam

Products Affected

- EMSAM

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

Emtriva

Products Affected

- EMTRIVA ORAL CAPSULE

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

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS* 50 MG/ML
- ENBREL SUBCUTANEOUS* KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Enbrel

Products Affected

- ENBREL SUBCUTANEOUS* 25 MG/0.5ML

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

Enbrel SureClick

Products Affected

- ENBREL SURECLICK SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Endometrin

Products Affected

- ENDOMETRIN

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

Enjuvia

Products Affected

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

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

Enjuvia

Products Affected

- ENJUVIA ORAL TABLET 1.25 MG

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

Enoxaparin Sodium

Products Affected

- *enoxaparin sodium*

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

Enpresse-28

Products Affected

- ENPRESSE-28

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

Entecavir

Products Affected

- *entecavir oral tablet 1 mg*

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

Epclusa

Products Affected

- EPCLUSA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Epiduo

Products Affected

- EPIDUO

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

Epiduo Forte

Products Affected

- EPIDUO FORTE

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

EPINEPHrine

Products Affected

- *epinephrine injection 0.3 mg/0.3ml, 0.15 mg/0.15ml*

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

EpiPen 2-Pak

Products Affected

- EPIPEN 2-PAK INJECTION

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

Epogen

Products Affected

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

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

Epoprostenol Sodium

Products Affected

- *epoprostenol sodium*

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

Eprosartan Mesylate

Products Affected

- *eprosartan mesylate*

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

Erivedge

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Errin

Products Affected

- ERRIN

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

Escitalopram Oxalate

Products Affected

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

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

Escitalopram Oxalate

Products Affected

- *escitalopram oxalate oral tablet 10 mg*

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

Esomeprazole Magnesium

Products Affected

- *esomeprazole magnesium*

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

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

Estradiol

Products Affected

- *estradiol transdermal patch weekly*

QL Criteria	1 box (4 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Estradiol

Products Affected

- *estradiol transdermal patch biweekly*

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

Estradiol-Norethindrone Acet

Products Affected

- *estradiol-norethindrone acet*

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

Estrogel

Products Affected

- ESTROGEL

QL Criteria	50 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Estrostep Fe

Products Affected

- ESTROSTEP FE

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

Eszopiclone

Products Affected

- *eszopiclone*

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

Evamist

Products Affected

- EVAMIST

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

EvenCare + Blood Glucose Test

Products Affected

- EVENCARE + BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EvenCare Blood Glucose Test

Products Affected

- EVENCARE BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EvenCare G2 Monitor

Products Affected

- EVENCARE G2 MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EvenCare G2 Test

Products Affected

- EVENCARE G2 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EvenCare G3 Monitor

Products Affected

- EVENCARE G3 MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

EvenCare G3 Test

Products Affected

- EVENCARE G3 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Evolution Autocode

Products Affected

- EVOLUTION AUTOCODE IN VITRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Evolution Autocode

Products Affected

- EVOLUTION AUTOCODE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Exjade

Products Affected

- EXJADE

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

Extavia

Products Affected

- EXTAVIA SUBCUTANEOUS* KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
QL Criteria	1 box (15 vials) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ez Smart Blood Glucose Test

Products Affected

- EZ SMART BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ez Smart Monitoring System

Products Affected

- EZ SMART MONITORING SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ez Smart Plus Glucose Test

Products Affected

- EZ SMART PLUS GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ez Smart Plus Monitoring Sys

Products Affected

- EZ SMART PLUS MONITORING SYS

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fabrazyme

Products Affected

- FABRAZYME

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

Falmina

Products Affected

- FALMINA

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

Famciclovir

Products Affected

- *famciclovir oral tablet 125 mg, 250 mg*

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

Famciclovir

Products Affected

- *famciclovir oral tablet 500 mg*

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

Fanapt

Products Affected

- FANAPT

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

Fanapt Titration Pack

Products Affected

- FANAPT TITRATION PACK

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

Felodipine ER

Products Affected

- *felodipine er*

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

Femcon Fe

Products Affected

- FEMCON FE

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

Femhrt Low Dose

Products Affected

- FEMHRT LOW DOSE

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

Femring

Products Affected

- FEMRING

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

Fenofibrate

Products Affected

- *fenofibrate oral*

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

Fenofibrate

Products Affected

- *fenofibrate oral*

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

Fenofibrate Micronized

Products Affected

- *fenofibrate micronized*

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

Fenofibric Acid

Products Affected

- *fenofibric acid oral tablet*

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

FentaNYL

Products Affected

- *fentanyl*

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

FentaNYL

Products Affected

- *fentanyl*

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

FentaNYL Citrate

Products Affected

- *fentanyl citrate buccal*

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

Ferriprox

Products Affected

- FERRIPROX

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

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Firazyr

Products Affected

- FIRAZYR

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

First-Progesterone VGS 100

Products Affected

- FIRST-PROGESTERONE VGS 100

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

First-Progesterone VGS 200

Products Affected

- FIRST-PROGESTERONE VGS 200

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

First-Progesterone VGS 25

Products Affected

- FIRST-PROGESTERONE VGS 25

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

First-Progesterone VGS 400

Products Affected

- FIRST-PROGESTERONE VGS 400

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

First-Progesterone VGS 50

Products Affected

- FIRST-PROGESTERONE VGS 50

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

Flebogamma DIF

Products Affected

- FLEBOGAMMA DIF

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

Flovent Diskus

Products Affected

- FLOVENT DISKUS

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

Flovent HFA

Products Affected

- FLOVENT HFA

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

Flunisolide

Products Affected

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

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule delayed release*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral tablet 10 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 20 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 40 mg*

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

FLUoxetine HCl

Products Affected

- *fluoxetine hcl oral capsule 10 mg*

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

Fluvastatin Sodium

Products Affected

- *fluvastatin sodium*

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

Fluvastatin Sodium ER

Products Affected

- *fluvastatin sodium er*

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

FluvoxaMINE Maleate

Products Affected

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

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

FluvoxaMINE Maleate

Products Affected

- *fluvoxamine maleate oral tablet 100 mg*

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

Focalin XR

Products Affected

- FOCALIN XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 35 MG, 25 MG

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Follistim AQ

Products Affected

- FOLLISTIM AQ

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

Fondaparinux Sodium

Products Affected

- *fondaparinux sodium*

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

FORA D10 2-in-1 Monitor

Products Affected

- FORA D10 2-IN-1 MONITOR

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

FORA D10 Blood Glucose Test

Products Affected

- FORA D10 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA D15g 2-in-1 Monitor

Products Affected

- FORA D15G 2-IN-1 MONITOR

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

FORA D15g Blood Glucose Test

Products Affected

- FORA D15G BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA D20 2-in-1 Monitor

Products Affected

- FORA D20 2-IN-1 MONITOR

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

FORA D20 Blood Glucose Test

Products Affected

- FORA D20 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA G20 Blood Glucose Test

Products Affected

- FORA G20 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA G30a Blood Glucose System

Products Affected

- FORA G30A BLOOD GLUCOSE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA G30a Blood Glucose Test

Products Affected

- FORA G30A BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fora GD20 Blood Glucose System

Products Affected

- FORA GD20 BLOOD GLUCOSE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fora GD20 Test

Products Affected

- FORA GD20 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V10 Blood Glucose System

Products Affected

- FORA V10 BLOOD GLUCOSE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V10 Blood Glucose Test

Products Affected

- FORA V10 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V12 Blood Glucose System

Products Affected

- FORA V12 BLOOD GLUCOSE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V12 Blood Glucose Test

Products Affected

- FORA V12 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V20 Blood Glucose System

Products Affected

- FORA V20 BLOOD GLUCOSE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V20 Blood Glucose Test

Products Affected

- FORA V20 BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V30a Blood Glucose System

Products Affected

- FORA V30A BLOOD GLUCOSE SYSTEM DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FORA V30a Blood Glucose Test

Products Affected

- FORA V30A BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ForaCare GD40 Monitor

Products Affected

- FORACARE GD40 MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ForaCare GD40 Test

Products Affected

- FORACARE GD40 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ForaCare premium V10

Products Affected

- FORACARE PREMIUM V10

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ForaCare premium V10 Test

Products Affected

- FORACARE PREMIUM V10 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Foradil Aerolizer

Products Affected

- FORADIL AEROLIZER

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

Forteo

Products Affected

- FORTEO SUBCUTANEOUS* SOLUTION
  600 MCG/2.4ML

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

Fortesta

Products Affected

- FORTESTA

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	4 pumps Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fortical

Products Affected

- FORTICAL

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 bottle Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fosamax Plus D

Products Affected

- FOSAMAX PLUS D

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	4 tablets Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Fragmin

Products Affected

- FRAGMIN SUBCUTANEOUS* SOLUTION
  5000 UNIT/0.2ML, 18000 UNT/0.72ML,
  12500 UNIT/0.5ML, 2500 UNIT/0.2ML,
  10000 UNIT/ML, 15000 UNIT/0.6ML

QL Criteria	1 syringe Per 1 day
Notes/ References	
Revision Date	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, 7500 UNIT/0.3ML,
  25000 UNIT/ML

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

FreeStyle InsuLinx Test

Products Affected

- FREESTYLE INSULINX TEST

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

FreeStyle Lite

Products Affected

- FREESTYLE LITE

QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

FreeStyle Lite Test

Products Affected

- FREESTYLE LITE TEST

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

FreeStyle Test

Products Affected

- FREESTYLE TEST

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

Frovatriptan Succinate

Products Affected

- *frovatriptan succinate*

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	9 tablets Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gabapentin

Products Affected

- *gabapentin oral tablet*

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

Gabapentin

Products Affected

- *gabapentin oral capsule*

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

Gammagard

Products Affected

- GAMMAGARD

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

Gammagard S/D Less IgA

Products Affected

- GAMMAGARD S/D LESS IGA

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

Gammaked

Products Affected

- GAMMAKED

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

Gammaplex

Products Affected

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

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

Gamunex-C

Products Affected

- GAMUNEX-C

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

Ganirelix Acetate

Products Affected

- *ganirelix acetate*

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

Gatifloxacin

Products Affected

- *gatifloxacin ophthalmic*

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

Gattex

Products Affected

- GATTEX

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

GaviLyte-C

Products Affected

- GAVILYTE-C

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

GaviLyte-G

Products Affected

- GAVILYTE-G

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

GE100 Blood Glucose Test

Products Affected

- *ge100 blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gelnique

Products Affected

- GELNIQUE TRANSDERMAL GEL 10 %

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

Gelnique

Products Affected

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

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

Generess FE

Products Affected

- GENERESS FE

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

Gianvi

Products Affected

- GIANVI

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

Giazo

Products Affected

- GIAZO

ST Criteria	Documented step through BALSALAZIDE
QL Criteria	6 tablets Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gildagia

Products Affected

- GILDAGIA

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

Gildess 1.5/30

Products Affected

- GILDESS 1.5/30

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

Gildess 1/20

Products Affected

- GILDESS 1/20

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

Gildess FE 1.5/30

Products Affected

- GILDESS FE 1.5/30

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

Gildess FE 1/20

Products Affected

- GILDESS FE 1/20

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

Gilenya

Products Affected

- GILENYA

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

Gilotrif

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glatopa

Products Affected

- GLATOPA

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

GlucaGen Diagnostic

Products Affected

- GLUCAGEN DIAGNOSTIC

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

GlucaGen HypoKit

Products Affected

- GLUCAGEN HYPOKIT

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

Glucocard 01 Blood Glucose

Products Affected

- GLUCOCARD 01 BLOOD GLUCOSE DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glucocard 01 Sensor Plus

Products Affected

- GLUCOCARD 01 SENSOR PLUS

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glucocard Expression Test

Products Affected

- GLUCOCARD EXPRESSION TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glucocard Vital Test

Products Affected

- GLUCOCARD VITAL TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Glucocard X-Sensor

Products Affected

- GLUCOCARD X-SENSOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GlucoCom Blood Glucose Monitor

Products Affected

- GLUCOCOM BLOOD GLUCOSE MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

GlucoCom Test

Products Affected

- GLUCOCOM TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gonal-f

Products Affected

- GONAL-F

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

Gonal-f RFF

Products Affected

- GONAL-F RFF

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

Gonal-f RFF Pen

Products Affected

- GONAL-F RFF PEN

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

Gonal-f RFF Rediject

Products Affected

- GONAL-F RFF REDIJECT

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

Gralise

Products Affected

- GRALISE ORAL TABLET 300 MG

ST Criteria	Documented step through GABAPENTIN
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise

Products Affected

- GRALISE ORAL TABLET 600 MG

ST Criteria	Documented step through GABAPENTIN
QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Gralise Starter

Products Affected

- GRALISE STARTER

ST Criteria	Documented step through GABAPENTIN
QL Criteria	1 starter pack Per 1 month
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Granisetron HCl

Products Affected

- *granisetron hcl oral*

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

GuanFACINE HCl ER

Products Affected

- *guanfacine hcl er*

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

Guardian REAL-Time System Ped

Products Affected

- GUARDIAN REAL-TIME SYSTEM PED

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

Halaven

Products Affected

- HALAVEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Halaven.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: May 23, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Harvoni

Products Affected

- HARVONI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Helixate FS

Products Affected

- HELIXATE FS

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

Hemofil M

Products Affected

- HEMOFIL M INTRAVENOUS* SOLUTION RECONSTITUTED 220-400 UNIT, 250 UNIT, 1000 UNIT, 1700 UNIT, 500 UNIT, 1501-2000 UNIT, 801-1500 UNIT, 401-800 UNIT

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

Hepsera

Products Affected

- HEPSERA

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

Hizentra

Products Affected

- HIZENTRA SUBCUTANEOUS* SOLUTION 10 GM/50ML, 1 GM/5ML, 4 GM/20ML, 2 GM/10ML

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

HM Nicotine

Products Affected

- *hm nicotine transdermal patch 24 hr 7 mg/24hr*

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

Horizant

Products Affected

- HORIZANT ORAL TABLET EXTENDEDRELEASE* 600 MG

ST Criteria	FOR POST-HERPTIC NEURALGIA: Documented step through gabapentin. FOR RESTLESS LESG SYNDROME: Documented step through gabapentin or ropinirole.
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Horizant

Products Affected

- HORIZANT ORAL TABLET EXTENDEDRELEASE* 300 MG

ST Criteria	FOR POST-HERPTIC NEURALGIA: Documented step through gabapentin. FOR RESTLESS LESG SYNDROME: Documented step through gabapentin or ropinirole.
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humate-P

Products Affected

- HUMATE-P INTRAVENOUS* SOLUTION RECONSTITUTED 500-1200 UNIT, 1000-2400 UNIT, 250-600 UNIT

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

Humira

Products Affected

- HUMIRA SUBCUTANEOUS* 10 MG/0.2ML

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

Humira

Products Affected

- HUMIRA SUBCUTANEOUS* 20 MG/0.4ML

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

Humira

Products Affected

- HUMIRA SUBCUTANEOUS* 40 MG/0.8ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 kit (2 pens)s
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humira Pediatric Crohns Start

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS* 40 MG/0.8ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 injections Per 21 months
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humira Pen

Products Affected

- HUMIRA PEN SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 kit (2 pens)s
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humira Pen-Crohns Starter

Products Affected

- HUMIRA PEN-CROHNS STARTER SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 injections Per 21 months
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Humira Pen-Psoriasis Starter

Products Affected

- HUMIRA PEN-PSORIASIS STARTER SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/immunologicalagents_rheumatoid_arthritis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 injections Per 28 months
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Hycamtin

Products Affected

- HYCAMTIN ORAL

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

Hydrocod Polst-CPM Polst ER

Products Affected

- *hydrocod polst-cpm polst er oral liquid extendedrelease**

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

HYDROmorphone HCl ER

Products Affected

- *hydromorphone hcl er*

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

Ibandronate Sodium

Products Affected

- *ibandronate sodium oral*

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

Iclusig

Products Affected

- ICLUSIG ORAL TABLET 45 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Iclusig

Products Affected

- ICLUSIG ORAL TABLET 15 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ilaris

Products Affected

- ILARIS

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

Imatinib Mesylate

Products Affected

- *imatinib mesylate oral tablet 100 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imatinib Mesylate

Products Affected

- *imatinib mesylate oral tablet 400 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Imiquimod

Products Affected

- *imiquimod external*

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

Implanon

Products Affected

- IMPLANON

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

Increlex

Products Affected

- INCRELEX

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

Infinity Blood Glucose Test

Products Affected

- INFINITY BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Inlyta

Products Affected

- INLYTA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Intelence

Products Affected

- INTELENCE ORAL TABLET 100 MG, 25 MG

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

Intelence

Products Affected

- INTELENCE ORAL TABLET 200 MG

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

Intron A

Products Affected

- INTRON A

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

Introvale

Products Affected

- INTROVALE

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

Invokana

Products Affected

- INVOKANA

ST Criteria	Documented step through METFORMIN 1500MG/day
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

Ipratropium Bromide

Products Affected

- *ipratropium bromide nasal*

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

Irbesartan

Products Affected

- *irbesartan*

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

Irbesartan-Hydrochlorothiazide

Products Affected

- *irbesartan-hydrochlorothiazide*

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

Isentress

Products Affected

- ISENTRESS ORAL TABLET

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

Isentress

Products Affected

- ISENTRESS ORAL TABLET CHEWABLE

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

Istodax

Products Affected

- ISTODAX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Istodax.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: May 23, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Itraconazole

Products Affected

- *itraconazole oral*

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Jakafi

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Janumet

Products Affected

- JANUMET

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

Janumet XR

Products Affected

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

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

Janumet XR

Products Affected

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

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

Januvia

Products Affected

- JANUVIA

ST Criteria	Documented step through METFORMIN ER (at least 1500mg/day) AND TRADJENTA/JENTADUETO or ONGLYZA/KOMBIGLYZE XR
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

Jentadueto

Products Affected

- JENTADUETO

ST Criteria	Documented step through METFORMIN 1500MG/day
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Jentadueto XR

Products Affected

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

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

Jentadueto XR

Products Affected

- JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HR* 5-1000 MG

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

Jevantique Lo

Products Affected

- *jevantique lo*

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

Jinteli

Products Affected

- JINTELI

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

Jolessa

Products Affected

- JOLESSA

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

Jolivette

Products Affected

- JOLIVETTE

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

Junel 1.5/30

Products Affected

- JUNEL 1.5/30

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

Junel 1/20

Products Affected

- JUNEL 1/20

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

Junel FE 1.5/30

Products Affected

- JUNEL FE 1.5/30

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

Junel FE 1/20

Products Affected

- JUNEL FE 1/20

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

Juxtapid

Products Affected

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

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

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 20 MG

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

Juxtapid

Products Affected

- JUXTAPID ORAL CAPSULE 5 MG, 10 MG

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

Kadian

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kalydeco

Products Affected

- KALYDECO ORAL TABLET

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

Kariva

Products Affected

- KARIVA

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

Kelnor 1/35

Products Affected

- KELNOR 1/35

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

Kepivance

Products Affected

- KEPIVANCE

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

Ketoconazole

Products Affected

- *ketoconazole oral*

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

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine ophthalmic*

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

Ketorolac Tromethamine

Products Affected

- *ketorolac tromethamine oral*

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

Kineret

Products Affected

- KINERET SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Kineret.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Kineret.html
QL Criteria	1 syringe Per 1 day
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Koate-DVI

Products Affected

- KOATE-DVI

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

Kogenate FS

Products Affected

- KOGENATE FS

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

Kogenate FS Bio-Set

Products Affected

- KOGENATE FS BIO-SET

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

Kombiglyze XR

Products Affected

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

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

Kombiglyze XR

Products Affected

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

ST Criteria	Documented step through METFORMIN 1500MG/day
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

Korlym

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/antidiabetic%20agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: February 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kovaltry

Products Affected

- KOVALTRY

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

Kroger Blood Glucose Test

Products Affected

- *kroger blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kroger Premium Glucose Test

Products Affected

- *kroger premium glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kroger Test

Products Affected

- *kroger test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Kurvelo

Products Affected

- KURVELO

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

Kuvan

Products Affected

- KUVAN ORAL PACKET 500 MG
- KUVAN ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

LamISIL

Products Affected

- LAMISIL ORAL PACKET 125 MG

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

LamISIL

Products Affected

- LAMISIL ORAL PACKET 187.5 MG

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

LamoTRIgine

Products Affected

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

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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 50 mg*

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

LamoTRIgine

Products Affected

- *lamotrigine oral tablet dispersible 25 mg*

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

LamoTRIgine ER

Products Affected

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

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

LamoTRIgine ER

Products Affected

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

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

LamoTRIgine ER

Products Affected

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

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

LamoTRIgine ER

Products Affected

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

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

Lansoprazole

Products Affected

- *lansoprazole oral capsule delayed release*

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

Lantus

Products Affected

- LANTUS

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

Lantus SoloStar

Products Affected

- LANTUS SOLOSTAR SUBCUTANEOUS*

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

Larin Fe 1.5/30

Products Affected

- LARIN FE 1.5/30

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

Lastacaft

Products Affected

- LASTACAFT

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

Latanoprost

Products Affected

- *latanoprost ophthalmic*

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

Latuda

Products Affected

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

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

Latuda

Products Affected

- LATUDA ORAL TABLET 80 MG

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

Leena

Products Affected

- LEENA

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

Leflunomide

Products Affected

- *leflunomide oral*

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

Lemtrada

Products Affected

- LEMTRADA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
QL Criteria	6 ML Per 365 Days
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lessina

Products Affected

- LESSINA

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

Letairis

Products Affected

- LETAIRIS

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

Leukine

Products Affected

- LEUKINE INTRAVENOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/GCSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Leuprolide Acetate

Products Affected

- *leuprolide acetate injection*

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

Levalbuterol Tartrate HFA

Products Affected

- *levalbuterol tartrate hfa*

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

LevETIRAcetam ER

Products Affected

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

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

LevETIRAcetam ER

Products Affected

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

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

Levocetirizine Dihydrochloride

Products Affected

- *levocetirizine dihydrochloride oral tablet*

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

Levocetirizine Dihydrochloride

Products Affected

- *levocetirizine dihydrochloride oral solution*

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

Levonest

Products Affected

- LEVONEST

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

Levonorgest-Eth Estrad 91-Day

Products Affected

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

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

Levonorgestrel-Ethinyl Estrad

Products Affected

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

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

Levora 0.15/30 (28)

Products Affected

- LEVORA 0.15/30 (28)

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

Lialda

Products Affected

- LIALDA

ST Criteria	Documented failure, contraindication or intolerance to Apriso
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

Liberty Blood Glucose Meter

Products Affected

- *liberty blood glucose meter*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Liberty Blood Glucose Monitor

Products Affected

- *liberty blood glucose monitor*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Liberty Next Generation Test

Products Affected

- LIBERTY NEXT GENERATION TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Liberty Nxt Generation Monitor

Products Affected

- LIBERTY NXT GENERATION MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Liberty Test

Products Affected

- *liberty test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lidocaine

Products Affected

- *lidocaine external ointment*

PA Criteria	Criteria Details
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 50 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 50 grams every 30 days, there must be a documented temporary need for anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, sensitivity to amide-type local anesthetics or any other component of the product, planned use on large surface area of the body as this can lead to increased toxicity, planned area of application includes severely traumatized skin (e.g.,mucosal or skin abrasion, eczema, burns), the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), of if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for temporary anesthesia for any of the following: Accessible mucous membranes of the oropharynx, skin and mucous membranes or stomatitis, or pain associated with a minor burns, including sunburn, abrasions of the skin, and insect bites.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months

PA Criteria	Criteria Details
Other Criteria	*Topical lidocaine ointment is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity. Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Approval can made up to an additional 50gms per 30 days. Higher additional quantities are not approvable *FOR ADULTS: A single application should not exceed 5 g of Lidocaine Ointment 5%, containing 250 mg of lidocaine base (equivalent chemically to approximately 300 mg of lidocaine hydrochloride). This is roughly equivalent to squeezing a six (6) inch length of ointment from the tube. In a 70 kg adult this dose equals 3.6 mg/kg (1.6 mg/lb) lidocaine base. No more than one-half tube, approximately 17-20 g of ointment or 850-1000 mg lidocaine base, should be administered in any one day. FOR CHILDREN: For children less than ten years who have a normal lean body mass and a normal lean body development, the maximum dose may be determined by the application of one of the standard pediatric drug formulas (e.g., Clark's rule). For example a child of five years weighing 50 lbs., the dose of lidocaine should not exceed 75-100 mg when calculated according to Clark's rule. In any case, the maximum amount of lidocaine administered should not exceed 4.5 mg/kg (2.0 mg/lb) of body weight ***Lidocaine toxicity resulting from transcutaneous absorption is theoretically possible. Signs and symptoms of systemic lidocaine toxicity include CNS excitation and/or depression, nervousness, confusion, dizziness, tinnitus, blurred or double vision, vomiting, twitching, tremors, seizures, unconsciousness, respiratory depression, bradycardia, hypotension, and cardiopulmonary arrest. If there is suspicion of lidocaine-related systemic toxicity, check lidocaine blood concentrations
QL Criteria	50 grams Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lidocaine

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Covered Uses	pain associated with post-herpetic neuralgia
Exclusion Criteria	
Required Medical Information	Documented diagnosis of pain associated with post-herpetic neuralgia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lidocaine-Prilocaine

Products Affected

- *lidocaine-prilocaine external cream*

PA Criteria	Criteria Details
Covered Uses	***AUTHORIZATION IS NOT REQUIRED FOR LESS THAN 50 GRAMS OF LIDOCAINE EVERY 30 DAYS*** For quantities over 50 grams every 30 days, there must be a documented temporary need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Exclusion Criteria	Documentation of any of the following: Planned area of application includes non-intact skin, Sensitivity to amide-type local anesthetics or any other component of the product, Planned use on large surface area of the body or for a period of time over 3 hours as this can lead to increased toxicity, the medication is being used in conjunction with a cosmetic procedure (i.e. hair removal), Use in situations where the drug may migrate into the middle ear, beyond the tympanic membrane, History of methemoglobinemia, or if the product will be compounded with other products that would alter the total dose/dosage form being administered
Required Medical Information	A documented need for topical anesthetic in either of the following situations: Normal, intact skin for local analgesia, or Genital mucous membranes for superficial minor surgery and as pretreatment for infiltration anesthesia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	*Topical lidocaine/prilocaine cream is used for temporary anesthesia. Prescription renewals for longer than 3 months require clinical documentation of medical necessity.Due to Safety Concerns higher quantities and prolonged use are not recommended. Renewal Duration: 3 months *Up to an additional 30 grams per 30 days. Higher additional quantities are not approvable.
QL Criteria	30 grams Per 30 Days
Notes/ References	

2016 Innovation Health Leap Drug Guide
Last update 12/2016

Revision Date	Prior Authorization: October 03, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lindane

Products Affected

- *lindane external lotion*

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

Linezolid

Products Affected

- *linezolid oral suspension reconstituted*

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

Linezolid

Products Affected

- *linezolid oral tablet*

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

Linzess

Products Affected

- LINZESS

ST Criteria	Documented step through LACTULOSE OR POLYETHYLENE GLYCOL
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Livalo

Products Affected

- LIVALO

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

Lo Loestrin Fe

Products Affected

- LO LOESTRIN FE

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

Loestrin Fe 1.5/30

Products Affected

- LOESTRIN FE 1.5/30

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

Loestrin Fe 1/20

Products Affected

- LOESTRIN FE 1/20

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

Lomedia 24 FE

Products Affected

- LOMEDIA 24 FE

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

Loryna

Products Affected

- LORYNA

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

LoSeasonique

Products Affected

- LOSEASONIQUE

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

Lovastatin

Products Affected

- *lovastatin*

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

Low-Ogestrel

Products Affected

- LOW-OGESTREL

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

Lumigan

Products Affected

- LUMIGAN OPHTHALMIC SOLUTION 0.01 %

PA Criteria	Criteria Details
Covered Uses	Glaucoma
Exclusion Criteria	
Required Medical Information	Documented step through latanoprost.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 bottle Per 1 month
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Lumizyme

Products Affected

- LUMIZYME

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

Lupaneta Pack

Products Affected

- LUPANETA PACK

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

Lupron Depot

Products Affected

- LUPRON DEPOT

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

Lupron Depot-Ped

Products Affected

- LUPRON DEPOT-PED

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

Lutera

Products Affected

- LUTERA

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

Lyrica

Products Affected

- LYRICA

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

Lyza

Products Affected

- LYZA

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

Malathion

Products Affected

- *malathion external*

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

Marlissa

Products Affected

- *marlissa*

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

Matzim LA

Products Affected

- MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HR* 180 MG, 300 MG, 420 MG, 360 MG

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

Matzim LA

Products Affected

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

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

Maxima Blood Glucose Test

Products Affected

- MAXIMA BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

MedroxyPROGESTERone Acetate

Products Affected

- *medroxyprogesterone acetate intramuscular* suspension*

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

Meijer Blood Glucose Test

Products Affected

- *meijer blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Meijer Premium Glucose Test

Products Affected

- *meijer premium glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Memantine HCl

Products Affected

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

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

Memantine HCl

Products Affected

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

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

Menopur

Products Affected

- MENOPUR

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

Menostar

Products Affected

- MENOSTAR

QL Criteria	1 box (4 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mesalamine

Products Affected

- *mesalamine oral*

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

Metadate ER

Products Affected

- METADATE ER ORAL TABLET EXTENDEDRELEASE* 20 MG

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Metaxalone

Products Affected

- *metaxalone oral tablet 400 mg*

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

MetFORMIN HCl ER (MOD)

Products Affected

- *metformin hcl er (mod)*

ST Criteria	Documented trial and failure of both generic Glucophage and generic Glucophage XR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Methamphetamine HCl

Products Affected

- *methamphetamine hcl*

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

Methylin

Products Affected

- METHYLIN ORAL TABLET CHEWABLE

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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl

Products Affected

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

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

Methylphenidate HCl

Products Affected

- *methylphenidate hcl oral tablet*

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

Methylphenidate HCl ER

Products Affected

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

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

Methylphenidate HCl ER

Products Affected

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

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Methylphenidate HCl ER

Products Affected

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

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Methylphenidate HCl ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Methylphenidate HCl ER

Products Affected

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

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

Methylphenidate HCl ER (CD)

Products Affected

- *methylphenidate hcl er (cd)*

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Methylphenidate HCl ER (LA)

Products Affected

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

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Methylphenidate HCl ER (LA)

Products Affected

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

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

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

Metoprolol Succinate ER

Products Affected

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

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

Metoprolol Succinate ER

Products Affected

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

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

Metoprolol Succinate ER

Products Affected

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

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

Miacalcin

Products Affected

- MIACALCIN INJECTION

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

Microdot Test

Products Affected

- MICRODOT TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Microgestin 1.5/30

Products Affected

- MICROGESTIN 1.5/30

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

Microgestin 1/20

Products Affected

- MICROGESTIN 1/20

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

Microgestin FE 1.5/30

Products Affected

- MICROGESTIN FE 1.5/30

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

Microgestin FE 1/20

Products Affected

- MICROGESTIN FE 1/20

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

Mimvey

Products Affected

- MIMVEY

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

Mircette

Products Affected

- MIRCETTE

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

Mirena (52 MG)

Products Affected

- MIRENA (52 MG)

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

Mirtazapine

Products Affected

- *mirtazapine oral*

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

Modafinil

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	Excessive daytime sleepiness associated with narcolepsy, Excessive daytime sleepiness associated with obstructive sleep apnea/hypopnea syndrome (OSAHS), shift work sleep disorder (SWSD)
Exclusion Criteria	Modafinil is not indicated to treat side effects caused by other medications.
Required Medical Information	FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH NARCOLEPSY: Documentation of diagnostic testing and clinical notations supporting diagnosis of Narcolepsy, such as MSLT, clinical progress notes, etc. (Failure to adequately support the diagnosis of narcolepsy may result in denial of coverage), and the patient has failed an adequate trial of at least TWO of the following immediate release stimulants (all available generically): Dexedrine, Ritalin, or Adderall. FOR THE TREATMENT OF EXCESSIVE DAYTIME SLEEPINESS ASSOCIATED WITH OBSTRUCTIVE SLEEP APNEA: The prescribing physician is a sleep specialist, ear, nose and throat, neurologist or pulmonologist or has obtained a consult from a sleep specialist, and a Standard Diagnostic Nocturnal Polysomnography (NPSG) has confirmed the diagnosis of OSA, and the patient has received nasal continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BIPAP) for at least 1 month, and CPAP or BIPAP therapy will be continued on a routine basis in combination with modafinil therapy, and the daytime fatigue is significantly impacting, impairing, or compromising the patient's ability to function normally, and the prescribing physician has established a patient care plan to treat the cause of OSA in conjunction with treating the daily fatigue
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	The plan also requires an unresponsive 2-week trial of 200mg per day dose before a 400mg per dose is authorized. (Doses up to 400mg/day given as a single dose have been well tolerated, but there is no consistent evidence that this dose confers additional benefit beyond that of the 200mg dose.)
QL Criteria	1 tablet Per 1 day

2016 Innovation Health Leap Drug Guide
Last update 12/2016

Notes/ References	
Revision Date	Prior Authorization: November 09, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Modicon (28)

Products Affected

- MODICON (28)

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

Monoclate-P

Products Affected

- MONOCLATE-P

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

Mono-Linyah

Products Affected

- MONO-LINYAH

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

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

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

Montelukast Sodium

Products Affected

- *montelukast sodium oral*

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

Morphine Sulfate ER

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Morphine Sulfate ER Beads

Products Affected

- *morphine sulfate er beads oral capsule extended release 24 hour 90 mg, 120 mg, 75 mg, 45 mg*

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

Mozobil

Products Affected

- MOZOBIL

PA Criteria	Criteria Details
Covered Uses	Mobilizing hematopoeitic stem cells to peripheral blood for the purpose of collection and subsequent transplantation in patients with non-Hodgkins lymphoma and multiple myeloma
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: April 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Multaq

Products Affected

- MULTAQ

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

MyGlucoHealth Test

Products Affected

- MYGLUCOHEALTH TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myobloc

Products Affected

- MYOBLOC

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

Myorisan

Products Affected

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

ST Criteria	Documented step through MINOCYCLINE OR DOXYCYCLINE
QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myrbetriq

Products Affected

- MYRBETRIQ

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Mytesi

Products Affected

- MYTESI

PA Criteria	Criteria Details
Covered Uses	Noninfectious diarrhea associated with HIV/AIDS infection
Exclusion Criteria	Diarrhea of infectious origin confirmed by diagnostic tests e.g. stool sample, blood culture, radiographic imaging, Diarrhea-predominant irritable bowel diseases such as Crohn's disease and ulcerative colitis
Required Medical Information	Diagnosis of noninfectious diarrhea associated with HIV/AIDS infection, currently taking antiviral therapy with adherence 80% or greater, and documentation of unsatisfactory effects with, intolerability to, or inability to take at least one antimotility agent such as Lomotil (atropine/diphenoxylate) or Imodium (loperamide).
Age Restrictions	18 Years of age or greater
Prescriber Restrictions	Gastroenterologist
Coverage Duration	6 months
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: December 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Myzilra

Products Affected

- MYZILRA

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

Naftifine HCl

Products Affected

- *naftifine hcl*

ST Criteria	Documented step through CLOTRIMAZOLE AND ECONAZOLE 1%
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Naftin

Products Affected

- NAFTIN EXTERNAL GEL 1 %

ST Criteria	Documented step through CLOTRIMAZOLE AND ECONAZOLE 1%
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Naglazyme

Products Affected

- NAGLAZYME

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

Naratriptan HCl

Products Affected

- *naratriptan hcl*

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

Natazia

Products Affected

- NATAZIA

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

Necon 0.5/35 (28)

Products Affected

- NECON 0.5/35 (28)

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

Necon 1/35 (28)

Products Affected

- NECON 1/35 (28)

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

Necon 1/50 (28)

Products Affected

- NECON 1/50 (28)

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

Necon 10/11 (28)

Products Affected

- NECON 10/11 (28)

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

Neulasta

Products Affected

- NEULASTA SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/GCSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neulasta Delivery Kit

Products Affected

- NEULASTA DELIVERY KIT SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/GCSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neupogen

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/GCSF.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neupro

Products Affected

- NEUPRO

ST Criteria	Documented step through TWO of the following: GABAPENTIN, ROPINIROLE, PRAMIPEXOLE (covered without trials of Parkinson's)
QL Criteria	1 patch Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Neutek 2Tek Glucose/Pressure

Products Affected

- NEUTEK 2TEK GLUCOSE/PRESSURE

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

Neutek 2Tek Test

Products Affected

- NEUTEK 2TEK TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nevirapine ER

Products Affected

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

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

Nevirapine ER

Products Affected

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

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

NexAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

NexIUM

Products Affected

- NEXIUM ORAL PACKET

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

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

Nexium 24HR

Products Affected

- NEXIUM 24HR ORAL CAPSULE DELAYED RELEASE

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

Nexplanon

Products Affected

- NEXPLANON

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

Next Choice One Dose

Products Affected

- NEXT CHOICE ONE DOSE

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

Nicoderm CQ

Products Affected

- NICODERM CQ

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

Nicotine

Products Affected

- *nicotine transdermal patch 24 hr*

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

Nicotine Step 1

Products Affected

- *nicotine step 1*

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

Nicotine Step 2

Products Affected

- *nicotine step 2*

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

Nicotine Step 3

Products Affected

- *nicotine step 3*

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

Nicotrol

Products Affected

- NICOTROL

QL Criteria	3 boxes-504 crtrg Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nicotrol NS

Products Affected

- NICOTROL NS

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

Nifediac CC

Products Affected

- NIFEDIAC CC ORAL TABLET EXTENDED RELEASE 24 HR* 30 MG

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

Nifediac CC

Products Affected

- NIFEDIAC CC ORAL TABLET EXTENDED RELEASE 24 HR* 60 MG

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

Nifedical XL

Products Affected

- NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HR* 30 MG

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

Nifedical XL

Products Affected

- NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HR* 60 MG

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

NIFEdipine ER

Products Affected

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

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

NIFEdipine ER

Products Affected

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

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

NIFEdipine ER Osmotic Release

Products Affected

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

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

NIFEdipine ER Osmotic Release

Products Affected

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

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

Nikki

Products Affected

- NIKKI

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

Nisoldipine ER

Products Affected

- *nisoldipine er oral tablet extended release 24 hr* 20 mg, 25.5 mg, 40 mg, 8.5 mg, 17 mg, 34 mg*

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

Nisoldipine ER

Products Affected

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

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

Nitroglycerin

Products Affected

- *nitroglycerin translingual solution*

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

Nora-BE

Products Affected

- NORA-BE

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

Norethindrone

Products Affected

- *norethindrone oral*

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

Norinyl 1+35 (28)

Products Affected

- NORINYL 1+35 (28)

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

Norinyl 1+50 (28)

Products Affected

- NORINYL 1+50 (28)

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

Norlyroc

Products Affected

- NORLYROC

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

Nortrel 0.5/35 (28)

Products Affected

- NORTREL 0.5/35 (28)

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

Nortrel 1/35 (21)

Products Affected

- NORTREL 1/35 (21)

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

Nortrel 1/35 (28)

Products Affected

- NORTREL 1/35 (28)

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

Nova Max Blood Glucose System

Products Affected

- NOVA MAX BLOOD GLUCOSE SYSTEM DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nova Max Glucose Test

Products Affected

- NOVA MAX GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Novarel

Products Affected

- NOVAREL

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

Novoeight

Products Affected

- NOVOEIGHT

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

NovoLIN 70/30

Products Affected

- NOVOLIN 70/30

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

NovoLIN 70/30 ReliOn

Products Affected

- NOVOLIN 70/30 RELION

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

NovoLIN N

Products Affected

- NOVOLIN N

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

NovoLIN N ReliOn

Products Affected

- NOVOLIN N RELION

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

NovoLIN R

Products Affected

- NOVOLIN R

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

NovoLIN R ReliOn

Products Affected

- NOVOLIN R RELION

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

NovoLOG

Products Affected

- NOVOLOG

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

NovoLOG FlexPen

Products Affected

- NOVOLOG FLEXPEN SUBCUTANEOUS*

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

NovoLOG Mix 70/30

Products Affected

- NOVOLOG MIX 70/30

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

NovoLOG Mix 70/30 FlexPen

Products Affected

- NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS*

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

NovoLOG PenFill

Products Affected

- NOVOLOG PENFILL SUBCUTANEOUS*

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

NovoSeven

Products Affected

- NOVOSEVEN

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

NovoSeven RT

Products Affected

- NOVOSEVEN RT

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

Noxafil

Products Affected

- NOXAFIL ORAL SUSPENSION

PA Criteria	Criteria Details
Covered Uses	Prophylaxis of Invasive Aspergillosis, prophylaxis of invasive candidiasis, treatment of oropharyngeal candidiasis in patients with disease refractory
Exclusion Criteria	Noxafil is NOT covered for members who are pursuing for prophylaxis of invasive aspergillosis or candidiasis who are not severely immunocompromised, for patients less that 13 years of age, patients without refractory disease to first-line antifungal agents, concomitant use with ergot alkaloids, simvastatin, or sirolimus, or concomitant use with CYP3A4 substrates such as, pimozide and quinidine.
Required Medical Information	Noxafil is covered for members who meet any ONE of the following criteria: (1) Prophylaxis of Invasive Aspergillosis in severely immunocompromised patients with active disease, (2) Prophylaxis of Invasive Candidiasis in severely immunocompromised patients with a history of developing invasive candidiasis refractory to fluconazole or who are intolerant to fluconazole, or (3) Treatment of Oropharyngeal Candidiasis in patients with disease refractory to fluconazole or itraconazole.
Age Restrictions	13 years of age or greater
Prescriber Restrictions	
Coverage Duration	Invasive Aspergillosis/Candidiasis prophylaxis- 3 months, Oropharyngeal Candidiasis-13 days
Other Criteria	Refractory fungal infection is defined as a previous occurrence of disease which failed to improve or respond to a standard course of antifungal therapy. Patients started on Noxafil as an inpatient will be allowed to continue therapy on an outpatient basis without interruption. Initial therapy of one 105ml bottle (7-day supply) will be covered to assure that therapy is not delayed while the prior authorization request is being reviewed.
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

2016 Innovation Health Leap Drug Guide
Last update 12/2016

Nucynta

Products Affected

- NUCYNTA

PA Criteria	Criteria Details
Covered Uses	Moderate to severe pain
Exclusion Criteria	Known or suspicious misuse of medications or illicit drug use.
Required Medical Information	Documented progression through the World Health Organization analgesic ladder, and step through, contraindication, or intolerance to two (2) alternative formulary immediate release opioids. Alternatives include morphine, oxycodone, hydromorphone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 3 years
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nucynta ER

Products Affected

- NUCYNTA ER

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nuedexta

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	Treatment of pseudobulbar affect in patients with amyotrophic lateral sclerosis (ALS) OR multiple sclerosis (MS).
Exclusion Criteria	Treatment in other types of emotional lability (i.e. Alzheimers disease and other dementias).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Nulojix

Products Affected

- NULOJIX

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

NuvaRing

Products Affected

- NUVARING

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

Nuwiq

Products Affected

- NUWIQ

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

Ocella

Products Affected

- OCELLA

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

Octagam

Products Affected

- OCTAGAM INTRAVENOUS* SOLUTION 1 GM/20ML, 10 GM/200ML, 2 GM/20ML, 20 GM/200ML, 2.5 GM/50ML, 25 GM/500ML, 5 GM/100ML

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

Octreotide Acetate

Products Affected

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

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

Odefsey

Products Affected

- ODEFSEY

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

Ogestrel

Products Affected

- OGESTREL

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

OLANZapine

Products Affected

- *olanzapine oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg*
- *olanzapine oral tablet dispersible*

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

OLANZapine

Products Affected

- *olanzapine oral tablet 2.5 mg*

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

OLANZapine-FLUoxetine HCl

Products Affected

- *olanzapine-fluoxetine hcl*

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

Oleptro

Products Affected

- OLEPTRO

ST Criteria	Documented step through TRAZADONE
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

Omega-3-acid Ethyl Esters

Products Affected

- *omega-3-acid ethyl esters*

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

Omeprazole-Sodium Bicarbonate

Products Affected

- *omeprazole-sodium bicarbonate oral capsule 20-1100 mg*

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

Omnaris

Products Affected

- OMNARIS

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

Omnitrope

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/growthhormone.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: 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

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

On Call Vivid Blood Glucose

Products Affected

- ON CALL VIVID BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ondansetron

Products Affected

- *ondansetron*

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

Ondansetron HCl

Products Affected

- *ondansetron hcl oral tablet 8 mg*

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

Ondansetron HCl

Products Affected

- *ondansetron hcl oral solution*

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

Ondansetron HCl

Products Affected

- *ondansetron hcl oral tablet 24 mg, 4 mg*

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

OneTouch Test

Products Affected

- ONETOUCH TEST

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

OneTouch Ultra Blue

Products Affected

- ONETOUCH ULTRA BLUE

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

OneTouch Verio

Products Affected

- ONETOUCH VERIO IN VITRO STRIP

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

Onfi

Products Affected

- ONFI ORAL SUSPENSION

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

Onfi

Products Affected

- ONFI ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment of seizures associated with Lennox-Gastaut syndrome
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Onglyza

Products Affected

- ONGLYZA

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

Opana ER

Products Affected

- OPANA ER ORAL

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Opsumit

Products Affected

- OPSUMIT

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

Optium Test

Products Affected

- OPTIUM TEST

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

OptiumEZ Test

Products Affected

- OPTIUMEZ TEST

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

Oravig

Products Affected

- ORAVIG

PA Criteria	Criteria Details
Covered Uses	Infection
Exclusion Criteria	
Required Medical Information	Have documented step through fluconazole, AND nystatin or clotrimazole troche
Age Restrictions	Less than 16 years old
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	14 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orencia

Products Affected

- ORENCIA SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
QL Criteria	4 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orencia

Products Affected

- ORENCIA INTRAVENOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orencia ClickJect

Products Affected

- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Orencia.html
QL Criteria	4 syringes Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orkambi

Products Affected

- ORKAMBI

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

Orkambi

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/cystic_fibrosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: December 21, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Orsythia

Products Affected

- ORSYTHIA

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

Ortho Micronor

Products Affected

- ORTHO MICRONOR

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

Ortho Tri-Cyclen (28)

Products Affected

- ORTHO TRI-CYCLEN (28)

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

Ortho Tri-Cyclen Lo

Products Affected

- ORTHO TRI-CYCLEN LO

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

Ortho-Cept (28)

Products Affected

- ORTHO-CEPT (28)

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

Ortho-Cyclen (28)

Products Affected

- ORTHO-CYCLEN (28)

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

Ortho-Novum 1/35 (28)

Products Affected

- ORTHO-NOVUM 1/35 (28)

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

Ortho-Novum 7/7/7 (28)

Products Affected

- ORTHO-NOVUM 7/7/7 (28)

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

Ovcon-35 (28)

Products Affected

- OVCON-35 (28)

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

Ovidrel

Products Affected

- OVIDREL

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

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR* 600 MG

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

Oxtellar XR

Products Affected

- OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR* 150 MG, 300 MG

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

Oxybutynin Chloride

Products Affected

- *oxybutynin chloride oral tablet*

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

Oxybutynin Chloride ER

Products Affected

- *oxybutynin chloride er*

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

Oxycodone-Ibuprofen

Products Affected

- *oxycodone-ibuprofen*

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

OxyCONTIN

Products Affected

- OXYCONTIN ORAL

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxymorphone HCl

Products Affected

- *oxymorphone hcl*

PA Criteria	Criteria Details
Covered Uses	Moderate to severe pain
Exclusion Criteria	Oxymorphone is not covered for members with no documented progression through the World Health Organization analgesic ladder, who have not tried and failed three (2) alternative formulary opioids, or who have a known hypersensitivity to morphine analogs (e.g. codeine).
Required Medical Information	Documented progression through the World Health Organization analgesic ladder and step through, contraindication, or intolerance to two (2) alternative formulary immediate release opioids. Alternatives include morphine, oxycodone, hydromorphone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxymorphone HCl ER

Products Affected

- *oxymorphone hcl er oral tablet extended release 12 hr* 10 mg*

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Oxymorphone HCl ER

Products Affected

- *oxymorphone hcl er oral tablet extended release 12 hr* 40 mg, 5 mg, 7.5 mg, 15 mg, 20 mg*

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

OxyMORphone HCl ER

Products Affected

- *oxymorphone hcl er oral tablet extended release 12 hr* 30 mg*

PA Criteria	Criteria Details
Covered Uses	Chronic paid due to malignant condition or severe pain requiring long term opioid.
Exclusion Criteria	No documented progression through the World Health Organization analgesic ladder
Required Medical Information	For new members with chronic pain due to a malignant condition (if previously stabilized) or for moderate to severe pain meeting the following criteria: documented progression through the World Health Organization analgesic ladder and documented step through extended release morphine sulfate tablets (MS Contin), or for the diagnosis of diabetic peripheral neuropathy (DPN) requesting Nucynta ER, a documented step through TWO (2) of the following drug/ drug classes (each agent must be from a different class): gabapentin, a tricyclic antidepressant (eg: amitriptyline), tramadol, Lyrica, a SNRI (e.g. venlafaxine, duloxetine) and documented step through extended release morphine sulfate tablets (MS Contin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	up to 1 year
Other Criteria	
QL Criteria	4 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release 24 hr* 1.5 mg, 9 mg, 3 mg*

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

Paliperidone ER

Products Affected

- *paliperidone er oral tablet extended release 24 hr* 6 mg*

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

Pancreaze

Products Affected

- PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 4200-10000 UNIT, 10500-25000 UNIT, 16800-40000 UNIT, 21000-37000 UNIT

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	Annual Review: 07/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pancrelipase (Lip-Prot-Amyl)

Products Affected

- *pancrelipase (lip-prot-amyl)*

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	Annual Review: 07/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Paragard Intrauterine Copper

Products Affected

- PARAGARD INTRAUTERINE COPPER

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

Paricalcitol

Products Affected

- *paricalcitol oral*

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

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 10 mg, 20 mg*

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

PARoxetine HCl

Products Affected

- *paroxetine hcl oral tablet 30 mg, 40 mg*

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

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release 24 hr* 25 mg*

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

PARoxetine HCl ER

Products Affected

- *paroxetine hcl er oral tablet extended release 24 hr* 37.5 mg, 12.5 mg*

ST Criteria	Documented step through paroxetine
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

PEG 3350/Electrolytes

Products Affected

- *peg 3350/electrolytes*

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

PEG-3350/Electrolytes

Products Affected

- *peg-3350/electrolytes*

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

Pegasys

Products Affected

- PEGASYS SUBCUTANEOUS* SOLUTION

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

Pegasys ProClick

Products Affected

- PEGASYS PROCLICK

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

Peg-Intron

Products Affected

- PEG-INTRON

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

Peg-Intron Redipen

Products Affected

- PEG-INTRON REDIPEN

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

Peg-Intron Redipen Pak 4

Products Affected

- PEG-INTRON REDIPEN PAK 4 SUBCUTANEOUS* KIT 50 MCG/0.5ML, 150 MCG/0.5ML, 120 MCG/0.5ML

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

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE* 250 MG

ST Criteria	Documented failure, contraindication or intolerance to Apriso
QL Criteria	16 capsules Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pentasa

Products Affected

- PENTASA ORAL CAPSULE EXTENDED RELEASE* 500 MG

ST Criteria	Documented failure, contraindication or intolerance to Apriso
QL Criteria	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Perforomist

Products Affected

- PERFOROMIST

PA Criteria	Criteria Details
Covered Uses	Chronic Obstructive Pulmonary Disease (COPD)
Exclusion Criteria	
Required Medical Information	Documented physical limitation that prevents the use of a non-nebulized long-acting bronchodilator with or without use of a spacer
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	4 milliliters Per 1 day
Notes/ References	Annual Review: 07/2016
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pertzye

Products Affected

- PERTZYE

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	Annual Review: 07/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pharmacist Choice Autocode

Products Affected

- PHARMACIST CHOICE AUTOCODE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Philith

Products Affected

- PHILITH

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

Picato

Products Affected

- PICATO EXTERNAL GEL 0.05 %

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

Picato

Products Affected

- PICATO EXTERNAL GEL 0.015 %

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

Pioglitazone HCl

Products Affected

- *pioglitazone hcl*

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

Pioglitazone HCl-Glimepiride

Products Affected

- *pioglitazone hcl-glimepiride*

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

Pioglitazone HCl-Metformin HCl

Products Affected

- *pioglitazone hcl-metformin hcl*

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

Plan B One-Step

Products Affected

- PLAN B ONE-STEP

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

Plegridy

Products Affected

- PLEGRIDY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
QL Criteria	2 inj Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Plegridy Starter Pack

Products Affected

- PLEGRIDY STARTER PACK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/multiple_sclerosis.html
QL Criteria	2 inj Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

PocketChem EZ Test

Products Affected

- POCKETCHEM EZ TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pomalyst

Products Affected

- POMALYST

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Portia-28

Products Affected

- PORTIA-28

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

Potiga

Products Affected

- POTIGA ORAL TABLET 200 MG, 400 MG, 300 MG

PA Criteria	Criteria Details
Covered Uses	partial-onset seizures
Exclusion Criteria	
Required Medical Information	documented diagnosis of partial-onset seizures
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Potiga

Products Affected

- POTIGA ORAL TABLET 50 MG

PA Criteria	Criteria Details
Covered Uses	partial-onset seizures
Exclusion Criteria	
Required Medical Information	documented diagnosis of partial-onset seizures
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Praluent

Products Affected

- PRALUENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pramipexole Dihydrochloride ER

Products Affected

- *pramipexole dihydrochloride er*

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

Pravastatin Sodium

Products Affected

- *pravastatin sodium*

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

Precision PCx

Products Affected

- PRECISION PCX

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

Precision PCX Plus Test

Products Affected

- PRECISION PCX PLUS TEST

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

Precision Point of Care Test

Products Affected

- PRECISION POINT OF CARE TEST

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

Precision QID Test

Products Affected

- PRECISION QID TEST

QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	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

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

Precision Xtra

Products Affected

- PRECISION XTRA DEVICE

QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Precision Xtra Blood Glucose

Products Affected

- PRECISION XTRA BLOOD GLUCOSE

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

Precision Xtra Monitor

Products Affected

- PRECISION XTRA MONITOR

QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prefest

Products Affected

- PREFEST

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

Pregnyl

Products Affected

- PREGNYL

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

Premarin

Products Affected

- PREMARIN ORAL

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

Premphase

Products Affected

- PREMPHASE

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

Prempro

Products Affected

- PREMPRO

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

Prevacid

Products Affected

- PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG

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

Previfem

Products Affected

- PREVIFEM

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

Prezista

Products Affected

- PREZISTA ORAL TABLET 600 MG, 75 MG, 150 MG

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

Prezista

Products Affected

- PREZISTA ORAL TABLET 800 MG

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

Prezista

Products Affected

- PREZISTA ORAL SUSPENSION

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

Pristiq

Products Affected

- PRISTIQ

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder
Exclusion Criteria	Patients taking products containing venlafaxine concomitantly, patients taking MAOIs concomitantly, or for use in pediatrics.
Required Medical Information	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses, or patient is a new member and has been receiving Pristiq therapy for more than 4 weeks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Privigen

Products Affected

- PRIVIGEN

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

ProAir HFA

Products Affected

- PROAIR HFA

ST Criteria	Documented step through VENTOLIN HFA
QL Criteria	2 inhalers Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Procrit

Products Affected

- PROCRIT

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

Prodigy AutoCode Blood Glucose

Products Affected

- PRODIGY AUTOCODE BLOOD GLUCOSE DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prodigy No Coding Blood Gluc

Products Affected

- PRODIGY NO CODING BLOOD GLUC

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Profilnine

Products Affected

- PROFILNINE INTRAVENOUS* SOLUTION RECONSTITUTED 1000 UNIT

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

Profilnine SD

Products Affected

- PROFILNINE SD

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

Progesterone Micronized

Products Affected

- *progesterone micronized oral*

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

Prolastin-C

Products Affected

- PROLASTIN-C INTRAVENOUS*
  SOLUTION RECONSTITUTED 1000 MG

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

Proleukin

Products Affected

- PROLEUKIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details:: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Interleukin%202.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: April 13, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Prolia

Products Affected

- PROLIA

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

Promacta

Products Affected

- PROMACTA ORAL TABLET 25 MG, 12.5 MG, 50 MG

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

Propafenone HCl ER

Products Affected

- *propafenone hcl er*

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

Proventil HFA

Products Affected

- PROVENTIL HFA

ST Criteria	Documented step through VENTOLIN HFA
QL Criteria	2 inhalers Per 1 month
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Pulmicort Flexhaler

Products Affected

- PULMICORT FLEXHALER

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

Pulmozyme

Products Affected

- PULMOZYME

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

Qnasl

Products Affected

- QNASL

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

Qnasl Childrens

Products Affected

- QNASL CHILDRENS

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

Quasense

Products Affected

- QUASENSE

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 100 mg, 50 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 25 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 300 mg, 400 mg*

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

QUEtiapine Fumarate

Products Affected

- *quetiapine fumarate oral tablet 200 mg*

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

Quillivant XR

Products Affected

- QUILLIVANT XR

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	12 milliliters Per 1 day
Notes/ References	

2016 Innovation Health Leap Drug Guide
Last update 12/2016

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

QuiNINE Sulfate

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Covered Uses	Malaria, babesiosis
Exclusion Criteria	Qualaquin is NOT covered for use for leg cramps, in women who are pregnant, or in patients with cerebral malaria in combination with doxycycline, tetracycline, or clindamycin (members should be treated with IV quinine per CDC (not oral).
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MALARIA - 7 days (42 capsules). BABESIOSIS - 10 days (60 capsules).
Other Criteria	
QL Criteria	42 capsules Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RA Blood Glucose Monitor

Products Affected

- *ra blood glucose monitor*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RA TRUEtest Test

Products Affected

- RA TRUETEST TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RABEprazole Sodium

Products Affected

- *rabeprazole sodium*

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

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

Rajani

Products Affected

- RAJANI

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

Ranexa

Products Affected

- RANEXA

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

Ravicti

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	12 bottles Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rebetol

Products Affected

- REBETOL ORAL SOLUTION

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

Rebif

Products Affected

- REBIF SUBCUTANEOUS*

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

Rebif Rebidose

Products Affected

- REBIF REBIDOSE SUBCUTANEOUS*

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

Rebif Rebidose Titration Pack

Products Affected

- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS*

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

Rebif Titration Pack

Products Affected

- REBIF TITRATION PACK SUBCUTANEOUS*

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

Reclast

Products Affected

- RECLAST

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

Reclipsen

Products Affected

- RECLIPSEN

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

Recombinate

Products Affected

- RECOMBINATE

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

Rectiv

Products Affected

- RECTIV

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

RefuAH Plus Blood Glucose Test

Products Affected

- REFUAH PLUS BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relenza Diskhaler

Products Affected

- RELENZA DISKHALER

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

ReliOn Confirm/micro Test

Products Affected

- RELION CONFIRM/MICRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ReliOn Prime Monitor

Products Affected

- RELION PRIME MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ReliOn Prime Test

Products Affected

- RELION PRIME TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ReliOn Ultima Test

Products Affected

- RELION ULTIMA TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relistor

Products Affected

- RELISTOR SUBCUTANEOUS* SOLUTION
  12 MG/0.6ML

PA Criteria	Criteria Details
Covered Uses	Opioid-induced constipation (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	Patients with advanced illness who are receiving palliative care, for the treatment of opioid-induced constipation when response to laxative therapy has not been sufficient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	
QL Criteria	0.6 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 09, 2016 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 (OIC) in adults with chronic non-cancer pain, OIC in adults with advanced illness
Exclusion Criteria	
Required Medical Information	Patients with advanced illness who are receiving palliative care, for the treatment of opioid-induced constipation when response to laxative therapy has not been sufficient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 Months
Other Criteria	
QL Criteria	0.4 ml Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: September 09, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Relpax

Products Affected

- RELPAX

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

Remicade

Products Affected

- REMICADE

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

Remodulin

Products Affected

- REMODULIN

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

Repaglinide-Metformin HCl

Products Affected

- *repaglinide-metformin hcl*

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

Repatha

Products Affected

- REPATHA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Repatha Pushtronex System

Products Affected

- REPATHA PUSHTRONEX SYSTEM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
QL Criteria	1 syringe Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Repatha SureClick

Products Affected

- REPATHA SURECLICK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/PCSK9.html
QL Criteria	2 syringes Per 28 Days
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Repronex

Products Affected

- REPRONEX

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

Rescula

Products Affected

- RESCULA

PA Criteria	Criteria Details
Covered Uses	Glaucoma
Exclusion Criteria	
Required Medical Information	Documented step through latanoprost.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 bottle Per 1 month
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Reveal Blood Glucose Test

Products Affected

- REVEAL BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Revlimid

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rexall Blood Glucose Test

Products Affected

- REXALL BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rexulti

Products Affected

- REXULTI

PA Criteria	Criteria Details
Covered Uses	Major Depressive Disorder (MDD), Schizophrenia
Exclusion Criteria	
Required Medical Information	Documented diagnosis of Major Depressive Disorder (MDD) or Schizophrenia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
ST Criteria	Trial of two atypical generic antipsychotic medications (i.e. aripiprazole, olanzapine, quetiapine, risperidone, or ziprasidone)
QL Criteria	1 tablet Per 1 Day
Notes/ References	Annual Review: 08/2016
Revision Date	Prior Authorization: December 02, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 200 MG

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

Reyataz

Products Affected

- REYATAZ ORAL CAPSULE 300 MG, 150 MG

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

RiaSTAP

Products Affected

- RIASTAP

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

Rightest GS100 Blood Glucose

Products Affected

- RIGHTEST GS100 BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rightest GS300 Blood Glucose

Products Affected

- RIGHTEST GS300 BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Rightest GS550 Blood Glucose

Products Affected

- RIGHTEST GS550 BLOOD GLUCOSE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 5 mg, 30 mg, 35 mg*

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

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet delayed release*

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	4 tablet Per 1 month
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Risedronate Sodium

Products Affected

- *risedronate sodium oral tablet 150 mg*

PA Criteria	Criteria Details
Covered Uses	Osteoporosis
Exclusion Criteria	No failure of formulary bisphosphonates, use in combination with one or more bisphosphonates.
Required Medical Information	Documentation of a trial and failure of generic alendronate weekly (70mg weekly dose)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 tablet Per 1 month
Notes/ References	Annual Review: 06/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

RisperiDONE

Products Affected

- *risperidone oral tablet dispersible 4 mg*
- *risperidone oral tablet 4 mg*

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

RisperiDONE

Products Affected

- *risperidone oral tablet 1 mg, 0.25 mg, 0.5 mg, 2 mg*
- *risperidone oral tablet dispersible 0.25 mg, 1 mg, 2 mg, 0.5 mg*

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

RisperiDONE

Products Affected

- *risperidone oral tablet 3 mg*
- *risperidone oral tablet dispersible 3 mg*

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

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 0.5 MG, 2 MG, 1 MG

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

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 3 MG

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

RisperiDONE M-TAB

Products Affected

- RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 4 MG

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

Rituxan

Products Affected

- RITUXAN INTRAVENOUS* SOLUTION

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

Rivastigmine

Products Affected

- *rivastigmine*

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

Rizatriptan Benzoate

Products Affected

- *rizatriptan benzoate*

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

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release 24 hr* 6 mg, 8 mg, 4 mg, 2 mg*

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

ROPINIRole HCl ER

Products Affected

- *ropinirole hcl er oral tablet extended release 24 hr* 12 mg*

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

Rosuvastatin Calcium

Products Affected

- *rosuvastatin calcium*

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

Rozerem

Products Affected

- ROZEREM

PA Criteria	Criteria Details
Covered Uses	Insomnia
Exclusion Criteria	
Required Medical Information	Step through either zolpidem tartrate or zalelpon, and through zolpidem tartrate extended-release
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/anticonvulasants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sabril

Products Affected

- SABRIL

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/anticonvulasants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	6 packets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Safyral

Products Affected

- SAFYRAL

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

Samsca

Products Affected

- SAMSCA ORAL TABLET 30 MG

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

Samsca

Products Affected

- SAMSCA ORAL TABLET 15 MG

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

Sancuso

Products Affected

- SANCUSO

PA Criteria	Criteria Details
Covered Uses	Chemotherapy induced nausea and vomiting
Exclusion Criteria	Cancer patients with non-chemotherapy related nausea and vomiting, patients with radiation-induced nausea and vomiting, patients with pregnancy-related nausea and vomiting, patients with post-operative nausea and vomiting
Required Medical Information	Patient is currently receiving chemotherapy and remains symptomatic despite treatment with oral ondansetron (Zofran) or oral granisetron (Kytril) or have documented inability to take oral antiemetics, including ODT formulations.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
QL Criteria	1 patch Per 1 month
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Saphris

Products Affected

- SAPHRIS

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

Saphris

Products Affected

- SAPHRIS

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

Savella

Products Affected

- SAVELLA

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	Peripheral Neuropathy(s) (other than diabetic), General Anxiety Disorder or Panic Disorder, Post-operative pain
Required Medical Information	Documentation of trials of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), and trial and failure of three (3) medications from the following drugs/drug classes: one tricyclic antidepressant (eg: amitriptyline), one muscle relaxant (eg: cyclobenzaprine), one SSRI, one SNRI, gabapentin, and tramadol
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Savella Titration Pack

Products Affected

- SAVELLA TITRATION PACK

PA Criteria	Criteria Details
Covered Uses	Fibromyalgia
Exclusion Criteria	Peripheral Neuropathy(s) (other than diabetic), General Anxiety Disorder or Panic Disorder, Post-operative pain
Required Medical Information	Documentation of trials of non-pharmacologic therapies (cognitive behavioral therapies, exercise etc.), and trial and failure of three (3) medications from the following drugs/drug classes: one tricyclic antidepressant (eg: amitriptyline), one muscle relaxant (eg: cyclobenzaprine), one SSRI, one SNRI, gabapentin, and tramadol
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Seasonique

Products Affected

- SEASONIQUE

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

Selzentry

Products Affected

- SELZENTRY

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

Sensipar

Products Affected

- SENSIPAR

ST Criteria	Documented step through CALCITRIOL (covered without trials for hyperparathyroidism and parathyroid carcinoma)
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Serevent Diskus

Products Affected

- SEREVENT DISKUS

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

SEROquel XR

Products Affected

- SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 150 MG, 200 MG

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder (MDD), Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 23, 2016 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, 50 MG

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder (MDD), Bipolar disorder or schizophrenia
Exclusion Criteria	
Required Medical Information	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
ST Criteria	Documented step through TWO of the following: RISPERIDONE, QUETIAPINE, ZIPRASIDONE, OLANZAPINE
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 23, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 25 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral concentrate*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 50 mg*

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

Sertraline HCl

Products Affected

- *sertraline hcl oral tablet 100 mg*

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

Sharobel

Products Affected

- SHAROBEL

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

Sildenafil Citrate

Products Affected

- *sildenafil citrate oral*

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

Simcor

Products Affected

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

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

Simcor

Products Affected

- SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 750-20 MG, 500-20 MG, 1000-20 MG

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simponi

Products Affected

- SIMPONI SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Simponi.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 syringe Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simponi Aria

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Simponi_Aria.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 vial Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simulect

Products Affected

- SIMULECT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ID/Simulect.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: March 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Simvastatin

Products Affected

- *simvastatin oral*

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

Smartest Blood Glucose Test

Products Affected

- SMARTEST BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Smartest Eject

Products Affected

- SMARTEST EJECT

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Smartest Protege

Products Affected

- SMARTEST PROTEGE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sodium Phenylbutyrate

Products Affected

- *sodium phenylbutyrate*
- *sodium phenylbutyrate oral powder 3 gm/tsp*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Solia

Products Affected

- SOLIA

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

Solus V2 Test

Products Affected

- SOLUS V2 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Somatuline Depot

Products Affected

- SOMATULINE DEPOT

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

Somavert

Products Affected

- SOMAVERT

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

Sovaldi

Products Affected

- SOVALDI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Spiriva HandiHaler

Products Affected

- SPIRIVA HANDIHALER

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

Spiriva Respimat

Products Affected

- SPIRIVA RESPIMAT INHALATION AEROSOL, SOLUTION 1.25 MCG/ACT

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

Sporanox

Products Affected

- SPORANOX ORAL SOLUTION

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

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

Sprintec 28

Products Affected

- SPRINTEC 28

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

Sprycel

Products Affected

- SPRYCEL ORAL TABLET 50 MG, 20 MG, 80 MG, 70 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sprycel

Products Affected

- SPRYCEL ORAL TABLET 140 MG, 100 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sronyx

Products Affected

- SRONYX

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

Stavzor

Products Affected

- STAVZOR

PA Criteria	Criteria Details
Covered Uses	Epilepsy, Bipolar disorder, Prophylaxis of migraine headaches
Exclusion Criteria	
Required Medical Information	FOR EPILEPSY OR BIPOLAR DISORDER: documentation of step through valproic acid capsules or divalproex sodium delayed release tablets. FOR PROPHYLAXIS OF MIGRAINE HEADACHES: documentation of step through 2 of the following: valproic acid capsules or divalproex sodium delayed release tablets, propranolol, or topiramate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stelara

Products Affected

- STELARA INTRAVENOUS*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Stelara.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 vials Per 30 Days
Notes/ References	
Revision Date	Prior Authorization: November 08, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stelara

Products Affected

- STELARA SUBCUTANEOUS*

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

Stimate

Products Affected

- STIMATE

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

Stiolto Respimat

Products Affected

- STIOLTO RESPIMAT

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

Stivarga

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Strattera

Products Affected

- STRATTERA

ST Criteria	Documented step through a STIMULANT
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

Striant

Products Affected

- STRIANT

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	2 buccal systems Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Stribild

Products Affected

- STRIBILD

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of human immunodeficiency virus (HIV), AND a documented viral load assay AND CD4 count indicating that the patient is stable on Stribild (stable or increase in CD4 counts AND viral load less than 50 copies/ml)(FOR renewals/continuations ONLY). For treatment naïve patients only, a documented resistance test within the past 3 months demonstrating virologic susceptibility to all of the following components of Stribild: elvitegravir, emtricitabine, and tenofovir AND a documented contraindication or intolerance or allergy or failure of an adequate trial of one month of one of the preferred regimens: Triumeq (dolutegravir/abacavir/lamivudine) OR Tivicay (dolutegravir) plus Truvada (tenofovir disoproxil fumarate/emtricitabine) OR Isentress (Raltegravir) plus Truvada (tenofovir disoproxil fumarate/emtricitabine) OR Prezista (Darunavir) plus Norvir (ritonavir) plus Truvada (tenofovir disoproxil fumarate/emtricitabine)
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 4-1 MG, 8-2 MG, 2-0.5 MG

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

PA Criteria	Criteria Details
Other Criteria	For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	3 films Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Suboxone

Products Affected

- SUBOXONE SUBLINGUAL FILM 12-3 MG

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

PA Criteria	Criteria Details
Other Criteria	For coverage of additional quantities, the following conditions must be met: FOR BUPRENORPHONE SL: Member is pregnant or breastfeeding (Up to 120 tablets in 30 days)or member has a documented contraindication, intolerance, or allergy to buprenorphine-naloxone sublingual tablet or Suboxone (will allow up to 90 tablets per month for max length of approval of 6 months). FOR SUBOXONE OR BUPRENORPHINE-NALOXONE SUBLINGUAL TABLET 2mg/0.5mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 12 mg/daily for total of 42 tablets/films in 7 days). FOR ZUBSOLBV 1.4mg/0.36mg: Member's dose is being titrated by physician for 7 day induction therapy (max dose 8.4 mg/daily for total of 42 tablets/films in 7 days). Note: Aetna considers the following as acceptable programs: Outpatient drug addiction treatment programs and/or counseling, 12- step programs focused on "drug" addiction such as Narcotics Anonymous (N.A.), Other accepted programs can be found at http://findtreatment.samhsa.gov/TreatmentLocator/faces/quickSearch.jspx. Aetna considers the following as non-acceptable programs: On-line programs such as Here to Help, 12-step programs that are not focused on "drug" addiction (ex: Alcoholics Anonymous).
QL Criteria	2 films Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: April 20, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SulfaSALAzine

Products Affected

- *sulfasalazine oral*

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

Sulfazine

Products Affected

- SULFAZINE

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

Sulfazine EC

Products Affected

- SULFAZINE EC

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

SUMAtriptan

Products Affected

- *sumatriptan nasal*

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

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous* solution 6 mg/0.5ml*

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

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate subcutaneous* 6 mg/0.5ml, 4 mg/0.5ml*
- *sumatriptan succinate subcutaneous* solution 4 mg/0.5ml*

QL Criteria	2 boxes (4 doses) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SUMAtriptan Succinate

Products Affected

- *sumatriptan succinate oral*

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

SUMAtriptan Succinate Refill

Products Affected

- *sumatriptan succinate refill subcutaneous**

QL Criteria	2 boxes (4 doses) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Supprelin LA

Products Affected

- SUPPRELIN LA

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

Sure Edge Glucose Monitor

Products Affected

- SURE EDGE GLUCOSE MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sure Edge Test

Products Affected

- SURE EDGE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SureChek Blood Glucose Monitor

Products Affected

- SURECHEK BLOOD GLUCOSE MONITOR DEVICE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SureChek Blood Glucose Test

Products Affected

- SURECHEK BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

SureStep Pro Linearity

Products Affected

- SURESTEP PRO LINEARITY

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

SureStep Pro Test

Products Affected

- SURESTEP PRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sure-Test EasyPlus Mini Meter

Products Affected

- SURE-TEST EASYPLUS MINI METER

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sure-Test EasyPlus Mini Test

Products Affected

- SURE-TEST EASYPLUS MINI TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Sutent

Products Affected

- SUTENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Syeda

Products Affected

- SYEDA

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

Sylatron

Products Affected

- SYLATRON SUBCUTANEOUS* KIT 300 MCG, 600 MCG, 4 X 300 MCG, 200 MCG, 4 X 200 MCG

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

Symbicort

Products Affected

- SYMBICORT

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

SymlinPen 120

Products Affected

- SYMLINPEN 120 SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Type 1 and Type 2 diabetes
Exclusion Criteria	
Required Medical Information	FOR TYPE 1 DIABETES: Patient must be using both basal insulin and short-acting insulin, and require three or more insulin injections daily, or using an insulin pump. FOR TYPE 2 DIABETES: Patient is receiving maximum tolerated doses of metformin, unless the patient is not a candidate for metformin therapy, and is using both basal insulin and short-acting insulin, and requires three or more insulin injections daily or is using an insulin pump, and failure to achieve adequate glycemic control despite individualized insulin management, defined as an A1C level is greater than 7% and less than 9%, and marked day-to-day variability in glucose levels (based on review of self-monitoring blood glucose levels), and home blood glucose monitoring is carried out three or more times per day, and is currently receiving individualized medical nutrition therapy by a registered dietician (requiring total daily carbohydrate intake monitoring), and is currently receiving ongoing care under the guidance of a healthcare professional skilled in the use of insulin and supported by the services of diabetes educators.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Discontinuation Criteria includes recurrent unexplained hypoglycemia that requires medical assistance, persistent clinically significant nausea or associated abdominal pain, noncompliance with self-monitoring of blood glucose concentrations, noncompliance with insulin dose adjustments, or non compliance with scheduled health care professional contacts or recommended clinic visits
QL Criteria	4 bottles Per 1 month
Notes/ References	Annual Review: 05/2016

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

SymlinPen 60

Products Affected

- SYMLINPEN 60 SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Type 1 and Type 2 diabetes
Exclusion Criteria	
Required Medical Information	FOR TYPE 1 DIABETES: Patient must be using both basal insulin and short-acting insulin, and require three or more insulin injections daily, or using an insulin pump. FOR TYPE 2 DIABETES: Patient is receiving maximum tolerated doses of metformin, unless the patient is not a candidate for metformin therapy, and is using both basal insulin and short-acting insulin, and requires three or more insulin injections daily or is using an insulin pump, and failure to achieve adequate glycemic control despite individualized insulin management, defined as an A1C level is greater than 7% and less than 9%, and marked day-to-day variability in glucose levels (based on review of self-monitoring blood glucose levels), and home blood glucose monitoring is carried out three or more times per day, and is currently receiving individualized medical nutrition therapy by a registered dietician (requiring total daily carbohydrate intake monitoring), and is currently receiving ongoing care under the guidance of a healthcare professional skilled in the use of insulin and supported by the services of diabetes educators.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Discontinuation Criteria includes recurrent unexplained hypoglycemia that requires medical assistance, persistent clinically significant nausea or associated abdominal pain, noncompliance with self-monitoring of blood glucose concentrations, noncompliance with insulin dose adjustments, or non compliance with scheduled health care professional contacts or recommended clinic visits
QL Criteria	4 pens Per 1 fill
Notes/ References	Annual Review: 05/2016

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

Synagis

Products Affected

- SYNAGIS

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

Synribo

Products Affected

- SYNRIBO

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

Taclonex

Products Affected

- TACLONEX EXTERNAL SUSPENSION

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

Take Action

Products Affected

- TAKE ACTION

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

Tamiflu

Products Affected

- TAMIFLU ORAL CAPSULE

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

Tamiflu

Products Affected

- TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML

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

Tarceva

Products Affected

- TARCEVA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Targretin

Products Affected

- TARGRETIN

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

Tasigna

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Taytulla

Products Affected

- TAYTULLA

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

Tazorac

Products Affected

- TAZORAC

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

Taztia XT

Products Affected

- TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG

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

Taztia XT

Products Affected

- TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 360 MG, 180 MG, 120 MG

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

Technivie

Products Affected

- TECHNIVIE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
QL Criteria	2 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tekturna

Products Affected

- TEKTURNA

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

Tekturna HCT

Products Affected

- TEKTURNA HCT

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

Telcare Blood Glucose Test

Products Affected

- TELCARE BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Telmisartan

Products Affected

- *telmisartan*

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

Telmisartan-Amlodipine

Products Affected

- *telmisartan-amlodipine*

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

Telmisartan-HCTZ

Products Affected

- *telmisartan-hctz*

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

Temazepam

Products Affected

- *temazepam oral capsule 7.5 mg, 22.5 mg*

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

Temozolomide

Products Affected

- *temozolomide*

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

Testim

Products Affected

- TESTIM

PA Criteria	Criteria Details
Covered Uses	Primary hypogonadism or hypogonadotropic hypogonadism
Exclusion Criteria	Female patients, male patients with carcinoma of the breast or suspected carcinoma of the prostate, or in a patient who will be using therapy for muscle building purposes
Required Medical Information	Documented diagnosis of primary hypogonadism or hypogonadotropic hypogonadism as defined by either one of the following: (1) Member has undergone bilateral orchiectomy (no total fasting serum testosterone levels required), or (2) Having two consecutive low total fasting serum testosterone levels (below the testing laboratory's reference range or below 300ng/dl if reference ranges are not available), or for persons with low normal total testosterone levels (above 300 ng/dL but below 400 ng/dL), two consecutive low free or bioavailable fasting serum testosterone levels (below the testing laboratory's reference range or less than 225 picomoles per liter (pmol/L) (6 ng/dL) if reference ranges are not available), Note: Two morning samples drawn between 7:00 a.m. and 10:00 a.m. obtained on two different days is required for NEW starts only.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Note: if there is conflict in the results of total testosterone and free testosterone testing, the free testosterone results will be used to evaluate the request.
QL Criteria	2 10 gm packets Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Testopel

Products Affected

- TESTOPEL

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

Testosterone

Products Affected

- *testosterone transdermal gel 50 mg/5gm (1%), 12.5 mg/act (1%)*

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

Testosterone

Products Affected

- *testosterone transdermal gel 10 mg/act (2%)*

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

Testosterone Cypionate

Products Affected

- *testosterone cypionate intramuscular* solution 200 mg/ml*

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

Testosterone Cypionate

Products Affected

- *testosterone cypionate intramuscular* solution 100 mg/ml*

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

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/huntingtons_xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 25 mg*

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

Teveten HCT

Products Affected

- TEVETEN HCT ORAL TABLET 600-25 MG

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

TGT Blood Glucose Test

Products Affected

- *tgt blood glucose test*

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Thalomid

Products Affected

- THALOMID

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

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 4 mg*

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

TiaGABine HCl

Products Affected

- *tiagabine hcl oral tablet 2 mg*

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

Tilia Fe

Products Affected

- TILIA FE

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

Tirosint

Products Affected

- TIROSINT

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

Tobramycin

Products Affected

- *tobramycin inhalation*

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

Tolterodine Tartrate

Products Affected

- *tolterodine tartrate*

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

Tolterodine Tartrate ER

Products Affected

- *tolterodine tartrate er*

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Topiramate

Products Affected

- *topiramate oral capsule sprinkle*

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

Toviaz

Products Affected

- TOVIAZ

ST Criteria	Documented step through OXYBUTYNIN or TROSPIUM AND VESICARE or MYRBETRIQ
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

Tracleer

Products Affected

- TRACLEER

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

Tradjenta

Products Affected

- TRADJENTA

ST Criteria	Documented step through METFORMIN 1500MG/day
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TraMADol HCl ER

Products Affected

- *tramadol hcl er oral tablet extended release 24 hr**

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

TraMADol HCl ER (Biphasic)

Products Affected

- *tramadol hcl er (biphasic)*

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

Tramadol-Acetaminophen

Products Affected

- *tramadol-acetaminophen*

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

Tranexamic Acid

Products Affected

- *tranexamic acid oral*

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

Travatan Z

Products Affected

- TRAVATAN Z

PA Criteria	Criteria Details
Covered Uses	Glaucoma
Exclusion Criteria	
Required Medical Information	Documented step through latanoprost.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretinoin

Products Affected

- *tretinoin external*

QL Criteria	50 grams Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretin-X

Products Affected

- TRETIN-X EXTERNAL CREAM 0.0375 %

ST Criteria	Documented step through TRETINOIN
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tretten

Products Affected

- TRETTEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Triamcinolone Acetonide

Products Affected

- *triamcinolone acetonide nasal aerosol†*

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
QL Criteria	1 bottle Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tribenzor

Products Affected

- TRIBENZOR

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

Tri-Legest Fe

Products Affected

- TRI-LEGEST FE

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Linyah

Products Affected

- TRI-LINYAH

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TriNessa (28)

Products Affected

- TRINESSA (28)

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Norinyl (28)

Products Affected

- TRI-NORINYL (28)

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Previfem

Products Affected

- TRI-PREVIFEM

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tri-Sprintec

Products Affected

- TRI-SPRINTEC

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trivora (28)

Products Affected

- TRIVORA (28)

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Trospium Chloride

Products Affected

- *trospium chloride*

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

Trospium Chloride ER

Products Affected

- *trospium chloride er*

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
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

TRUEtest Test

Products Affected

- TRUETEST TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TrueTrack Test

Products Affected

- TRUETRACK TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Truvada

Products Affected

- TRUVADA

PA Criteria	Criteria Details
Covered Uses	HIV Infection, HIV Infection Pre-exposure Prophylaxis
Exclusion Criteria	Truvada is NOT covered for a use not approved by the FDA or if the use is unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use)
Required Medical Information	Truvada is covered for members who have a documented diagnosis of human immunodeficiency virus (HIV) OR a documented diagnosis of initiating therapy for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults at high risk AND documentation of a negative HIV antibody test taken immediately before starting Truvada for PrEP AND every 3 months thereafter while on therapy. Confirmation that creatinine clearance value greater than or equal to 60 mL/min before initiating Truvada for PrEP AND Serum creatinine and calculate creatinine clearance checks performed at 3 months after initiation and then every 6 months thereafter. NOTE: Members may receive a 30 days' supply of medication upon initial request of Truvada for PrEP diagnosis. After 30 days, above criteria must be met.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HIV-1 infection: 3 years. Pre-exposure prophylaxis: 3 months.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: September 11, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Truvada

Products Affected

- TRUVADA

PA Criteria	Criteria Details
Covered Uses	A documented diagnosis of human immunodeficiency virus (HIV) in a patient who weighs 17KG or more OR initiating therapy for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 in adults at high risk who have 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 is greater than or equal to 60 mL/min before initiating Truvada for PrEP, and serum creatinine and calculate creatinine clearance checks performed at 3 months after initiation and then every 6 months thereafter. NOTE: Members may receive a 30 days' supply of medication upon initial request of Truvada for PrEP diagnosis. After 30 days, above criteria must be met.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	none
Prescriber Restrictions	
Coverage Duration	36 months HIV, 1 month initial PREP, 3 month PREP renewal
Other Criteria	4. Gilead Sciences, Inc.Truvada® (emtricitabine/tenofovir disoproxil fumarate) tablets, for oral use Foster City, CA: Gilead Sciences; 2004. Available at http://gilead.com/~/media/files/pdfs/medicines/hiv/truvada/truvada_pi.pdf Accessed June 9th, 2016.
Notes/ References	
Revision Date	Prior Authorization: July 07, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tudorza Pressair

Products Affected

- TUDORZA PRESSAIR INHALATION AEROSOL POWDER, BREATH ACTIVATED 400 MCG/ACT

QL Criteria	1 inhaler Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

TussiCaps

Products Affected

- TUSSICAPS

QL Criteria	20 capsules Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tykerb

Products Affected

- TYKERB

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Tyzeka

Products Affected

- TYZEKA

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

Uceris

Products Affected

- UCERIS ORAL

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ulesfia

Products Affected

- ULESFIA

QL Criteria	3 bottles Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Uloric

Products Affected

- ULORIC

ST Criteria	Documented step through ALLOPURINOL
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ultima Test

Products Affected

- ULTIMA TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

UltraTRAK Active

Products Affected

- ULTRATRAK ACTIVE

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

UltraTRAK PRO

Products Affected

- ULTRATRAK PRO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

UltraTRAK PRO Test

Products Affected

- ULTRATRAK PRO TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

UltraTRAK Ultimate Monitor

Products Affected

- ULTRATRAK ULTIMATE MONITOR

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

UltraTRAK Ultimate Test

Products Affected

- ULTRATRAK ULTIMATE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ultresa

Products Affected

- ULTRESA

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	Annual Review: 07/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valcyte

Products Affected

- VALCYTE

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ValGANciclovir HCl

Products Affected

- *valganciclovir hcl*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ID/antiviraloraltopical.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valsartan

Products Affected

- *valsartan*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Valsartan-Hydrochlorothiazide

Products Affected

- *valsartan-hydrochlorothiazide*

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

Vectibix

Products Affected

- VECTIBIX INTRAVENOUS* SOLUTION
  400 MG/20ML, 100 MG/5ML

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Velcade

Products Affected

- VELCADE INJECTION

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Velivet

Products Affected

- VELIVET

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 50 mg*

QL Criteria	6 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 100 mg, 25 mg*

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 37.5 mg*

QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl

Products Affected

- *venlafaxine hcl oral tablet 75 mg*

QL Criteria	5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 75 mg, 37.5 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Venlafaxine HCl ER

Products Affected

- *venlafaxine hcl er oral capsule extended release 24 hour 150 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Veramyst

Products Affected

- VERAMYST

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 300 mg, 100 mg*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Verapamil HCl ER

Products Affected

- *verapamil hcl er oral capsule extended release 24 hour 200 mg*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

VESIcare

Products Affected

- VESICARE

ST Criteria	Documented step through OXYBUTYNIN OR TROSPIUM IR
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

Victory AGM-4000 Test

Products Affected

- VICTORY AGM-4000 TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Victory Blood Glucose System

Products Affected

- VICTORY BLOOD GLUCOSE SYSTEM

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Victoza

Products Affected

- VICTOZA SUBCUTANEOUS*

PA Criteria	Criteria Details
Covered Uses	Type 2 Diabetes Mellitus (NIDDM)
Exclusion Criteria	Diagnosis of metabolic syndrome or any other pre-diabetic diagnosis, diagnosis of Type 1 Diabetes, treatment of diabetic ketoacidosis, pediatric patients, patients with multiple endocrine neoplasia syndrome type 2 (MEN2), family history of medullary thyroid carcinoma (MTC), patients with a history of pancreatitis
Required Medical Information	Patient must an A1C level is greater than 6.5%, have failed to obtain adequate glycemic control on maximum tolerated dose of metformin (unless the patient is not a candidate for metformin therapy) and a second antidiabetic agent (either a sulfonylurea, a thiazolidinedione (TZD), a DPP4-inhibitor or basal insulin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	
QL Criteria	1 box-2 or 3 pens Per 1 month
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Victrelis

Products Affected

- VICTRELIS

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	10 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viekira Pak

Products Affected

- VIEKIRA PAK

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
QL Criteria	4 EA Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viekira XR

Products Affected

- VIEKIRA XR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
QL Criteria	84 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viibryd

Products Affected

- VIIBRYD ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viibryd

Products Affected

- VIIBRYD ORAL KIT

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viibryd

Products Affected

- VIIBRYD ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	1 tablet Per 1 day
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viibryd Starter Pack

Products Affected

- VIIBRYD STARTER PACK

PA Criteria	Criteria Details
Covered Uses	Major depressive disorder
Exclusion Criteria	
Required Medical Information	Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Notes/ References	Annual Review: 05/2016
Revision Date	Prior Authorization: October 28, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vimpat

Products Affected

- VIMPAT ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	partial-onset seizures
Exclusion Criteria	
Required Medical Information	A documented diagnosis of partial-onset seizures and documentation of a trial and failure with one of the following agents: carbamazepine, divalproex dr/er/sprinkle, gabapentin, lamotrigine, levetiracetam/ER, oxcarbazepine, phenytoin, topiramate, valproic acid, or zonisamide.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: February 25, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viokace

Products Affected

- VIOKACE

PA Criteria	Criteria Details
Covered Uses	Exocrine pancreatic Insufficiency
Exclusion Criteria	Uses not approved by the FDA, uses unapproved and not supported by the literature or evidence as an accepted off-label use. (see Off-Label Use Policy for determining accepted use).
Required Medical Information	Diagnosis of exocrine pancreatic insufficiency due to cystic fibrosis or other conditions and a documented trial of two weeks of Zenpep.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viorele

Products Affected

- *viorele*

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viramune XR

Products Affected

- VIRAMUNE XR ORAL TABLET
  EXTENDED RELEASE 24 HR* 100 MG

QL Criteria	3 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Viread

Products Affected

- VIREAD ORAL TABLET

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vistogard

Products Affected

- VISTOGARD

QL Criteria	20 packs Per 1 prescription
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vocal Point Blood Glucose Test

Products Affected

- VOCAL POINT BLOOD GLUCOSE TEST

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Voriconazole

Products Affected

- *voriconazole oral tablet*

PA Criteria	Criteria Details
Covered Uses	Fungal infections
Exclusion Criteria	
Required Medical Information	Diagnosis of invasive aspergillosis or with a serious systemic fungal infection caused by Scedosporium apiospermum and Fusarium spp., for the treatment of esophageal candidiasis that is resistant to treatment with fluconazole and itraconazole, or for the treatment of candidemia in non-neutropenic patients and the following Candida infections: disseminated infections in skin and infections in abdomen, kidney, bladder wall, and wounds that are unresponsive to treatment with fluconazole (Continue therapy for 14 days after the patient is afebrile and blood cultures are negative).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Invasive aspergillosis: 12 weeks, Oral Candidiasis: 3 weeks MAX, Candidemia: 12 weeks
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Votrient

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vpriv

Products Affected

- VPRIV

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vytorin

Products Affected

- VYTORIN

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Vyvanse

Products Affected

- VYVANSE

PA Criteria	Criteria Details
Covered Uses	Attention Deficit Disorder(ADD), Attention Deficit Hyperactivity Disorder(ADHD)
Exclusion Criteria	Not covered as first-line treatment, not approved for reasons of convenience/compliance, either on the part of the patient or their provider, not covered in members with contraindications to stimulant therapy, and not covered for treatment of conditions other than ADD or ADHD including, but not limited to: cancer related fatigue, human immunodeficiency virus (HIV)-positive related fatigue, finding related to coordination/incoordination- impaired cognition (pediatrics), paraphilia (adjunct), shivering, postanesthesia (treatment and prophylaxis), traumatic brain injury
Required Medical Information	Documented diagnosis of adult ADD or ADHD OR documented diagnosis of childhood ADHD onset with history of previous treatment, with documentation of symptoms significantly impacting, impairing, or compromising the patient's ability to function normally (i.e., attend/maintain academic enrollment or employment), and either of the following: (1)for requests for Dextroamphetamine/Amphetamine ER, Methyphenidate CD, Daytrana, Dexmethylphenidate XR, Methylphenidate ER, Methylphenidate ER-LA, Quillivant XR: documentation of intolerance to appropriately dosed and administered regular/immediate acting stimulants, or (2) for requests for Vyvanse: documentation of intolerance to appropriately dosed and administered regular/immediate acting amphetamine salts and dextroamphetamine/amphetamine ER.
Age Restrictions	19 years and greater
Prescriber Restrictions	
Coverage Duration	1 Year
Other Criteria	
QL Criteria	2 capsules Per 1 Day
Notes/ References	

Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

WaveSense KeyNote Pro Meter

Products Affected

- WAVESENSE KEYNOTE PRO METER

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	1 meter Per 1 year
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

WaveSense Presto

Products Affected

- WAVESENSE PRESTO

PA Criteria	Criteria Details
Covered Uses	Type II Diabetes Mellitus
Exclusion Criteria	
Required Medical Information	There is documentation the member has a physical limitation that makes utilization of an Abbott or Lifescan product unsafe, inaccurate or otherwise not feasible. Such limitations may include, but are not limited to, manual dexterity or visual impairment issues not accommodated by the features and capabilities of the Abbott or Lifescan product lines, or the member has hematocrit levels which are chronically less than 30% or greater than 55%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years, limit one meter per year
Other Criteria	
QL Criteria	300 strips Per 1 month
Notes/ References	
Revision Date	Prior Authorization: November 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Welchol

Products Affected

- WELCHOL ORAL PACKET

QL Criteria	1 pack Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wera

Products Affected

- WERA

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wide-Seal Diaphragm 60

Products Affected

- WIDE-SEAL DIAPHRAGM 60

QL Criteria	1 diaphram Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wide-Seal Diaphragm 65

Products Affected

- WIDE-SEAL DIAPHRAGM 65

QL Criteria	1 diaphram Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wide-Seal Diaphragm 70

Products Affected

- WIDE-SEAL DIAPHRAGM 70

QL Criteria	1 diaphram Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wide-Seal Diaphragm 75

Products Affected

- WIDE-SEAL DIAPHRAGM 75

QL Criteria	1 diaphram Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wide-Seal Diaphragm 80

Products Affected

- WIDE-SEAL DIAPHRAGM 80

QL Criteria	1 diaphram Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wide-Seal Diaphragm 85

Products Affected

- WIDE-SEAL DIAPHRAGM 85

QL Criteria	1 diaphram Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wide-Seal Diaphragm 90

Products Affected

- WIDE-SEAL DIAPHRAGM 90

QL Criteria	1 diaphram Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wide-Seal Diaphragm 95

Products Affected

- WIDE-SEAL DIAPHRAGM 95

QL Criteria	1 diaphram Per 1 year
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wilate

Products Affected

- WILATE INTRAVENOUS* KIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Wymzya Fe

Products Affected

- WYMZYA FE

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xalkori

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeljanz

Products Affected

- XELJANZ

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeljanz XR

Products Affected

- XELJANZ XR

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/Xeljanz_XeljanzXR.html
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: November 01, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xenazine

Products Affected

- XENAZINE ORAL TABLET 25 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/huntingtons_xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xenazine

Products Affected

- XENAZINE ORAL TABLET 12.5 MG

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/huntingtons_xenazine.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xeomin

Products Affected

- XEOMIN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/botulinum_toxin.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xgeva

Products Affected

- XGEVA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xiaflex

Products Affected

- XIAFLEX

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/dupuytrens_contracture_treatments.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
Covered Uses	Hepatic Encephalopathy, Irritable Bowel Syndrome (IBS) with Diarrhea.
Exclusion Criteria	Pregnancy, Severe hepatic impairment (child-Pugh C)
Required Medical Information	FOR HEPATIC ENCHEPHALOPATHY: Member must have a documented diagnosis and be 18 years and older. FOR IBS WITH DIARRHEA: Member must have a documented diagnosis and must have been prescribed a 14-day course of therapy with three times a day dosing. For reauthorization of 2nd or 3rd course of therapy, there must be at least a 10-week treatment free period from the previous course of therapy.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	HEPATIC ENCEPHALOPATHY: 1 year. IBS: 14 days.
Other Criteria	
QL Criteria	3 tablets Per 1 day
Notes/ References	Annual Review: 04/2016
Revision Date	Prior Authorization: July 21, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xifaxan

Products Affected

- XIFAXAN ORAL TABLET 200 MG

QL Criteria	9 tablets Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xtandi

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xulane

Products Affected

- XULANE

QL Criteria	1 box (3 patches) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xuriden

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/metabolic_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 packets Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: August 31, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyntha

Products Affected

- XYNTHA INTRAVENOUS* KIT 2000 UNIT, 1000 UNIT, 250 UNIT, 500 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyntha Solofuse

Products Affected

- XYNTHA SOLOFUSE INTRAVENOUS*
  KIT 3000 UNIT

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MISC/bloodproducts_coagulants.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 10, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Xyrem

Products Affected

- XYREM

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/CNS/cataplexy-xyrem.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: October 27, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Yasmin 28

Products Affected

- YASMIN 28

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

YAZ

Products Affected

- YAZ

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Yervoy

Products Affected

- YERVOY

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zaleplon

Products Affected

- *zaleplon*

QL Criteria	1 capsule Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zarah

Products Affected

- ZARAH

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zavesca

Products Affected

- ZAVESCA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ENDO/lysosomal_storage.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	3 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zegerid OTC

Products Affected

- ZEGERID OTC

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

Zelapar

Products Affected

- ZELAPAR

ST Criteria	Documented step through SELEGILINE
QL Criteria	2 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zelboraf

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	8 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zemaira

Products Affected

- ZEMAIRA

PA Criteria	Criteria Details
Covered Uses	pending
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	pending
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenatane

Products Affected

- ZENATANE

ST Criteria	Documented step through MINOCYCLINE OR DOXYCYCLINE
QL Criteria	2 capsules Per 1 day
Notes/ References	Annual Review: 02/2016
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenchent

Products Affected

- ZENCHENT

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zenchent FE

Products Affected

- ZENCHENT FE

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zepatier

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
ST Criteria	http://www.aetna.com/products/rxnonmedicare/data/2016/GI/hepatitis_c.html
QL Criteria	1 tablet Per 1 Day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zetia

Products Affected

- ZETIA

ST Criteria	Documented step through TWO of the following: ATORVASTATIN, LOVASTATIN, PRAVASTATIN, SIMVASTATIN
QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zetonna

Products Affected

- ZETONNA

ST Criteria	Documented step through FLUTICASONE PROPIONATE AND FLUNISOLIDE
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zioptan

Products Affected

- ZIOPTAN

PA Criteria	Criteria Details
Covered Uses	Glaucoma
Exclusion Criteria	
Required Medical Information	Documented step through latanoprost.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
QL Criteria	1 box Per 1 fill
Notes/ References	Annual Review: 03/2016
Revision Date	Prior Authorization: October 14, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Ziprasidone HCl

Products Affected

- *ziprasidone hcl*

QL Criteria	2 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zirgan

Products Affected

- ZIRGAN

QL Criteria	5 grams Per 1 fill
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zoledronic Acid

Products Affected

- *zoledronic acid intravenous* concentrate*
- *zoledronic acid intravenous* solution*

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zolinza

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 capsules Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

ZOLMitriptan

Products Affected

- *zolmitriptan oral*

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	6 tablets Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zolpidem Tartrate

Products Affected

- *zolpidem tartrate oral*

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

Zolpidem Tartrate ER

Products Affected

- *zolpidem tartrate er*

QL Criteria	1 tablet Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zometa

Products Affected

- ZOMETA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/MUSC/bone_disease_agents.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zomig

Products Affected

- ZOMIG NASAL SOLUTION 5 MG

ST Criteria	Documented step through TWO of the following: SUMATRIPTAN, NARATRIPTAN, RIZATRIPTAN
QL Criteria	1 box (6 doses) Per 1 month
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zovia 1/35E (28)

Products Affected

- ZOVIA 1/35E (28)

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zovia 1/50E (28)

Products Affected

- ZOVIA 1/50E (28)

QL Criteria	1.5 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zovirax

Products Affected

- ZOVIRAX EXTERNAL CREAM

ST Criteria	Documented step through ORAL ACYCLOVIR
Notes/ References	
Revision Date	Prior Authorization: August 25, 2015 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Zytiga

Products Affected

- ZYTIGA

PA Criteria	Criteria Details
Covered Uses	Refer to the clinical policy bulletin for details: http://www.aetna.com/products/rxnonmedicare/data/2016/ANEOPL/Antineoplastics.html
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Refer to the clinical policy bulletin above for details.
Other Criteria	
QL Criteria	4 tablets Per 1 day
Notes/ References	
Revision Date	Prior Authorization: May 27, 2016 Step Therapy: August 25, 2015 Quantity Limits: August 25, 2015

Index

acamprosate calcium 1
ACCU-CHEK ACTIVE 2
ACCU-CHEK AVIVA IN VITRO STRIP 3
ACCU-CHEK AVIVA PLUS IN VITRO 4
ACCU-CHEK COMPACT PLUS 5
ACCU-CHEK COMPACT TEST DRUM 6
ACCU-CHEK SMARTVIEW 7
ACCUTREND GLUCOSE 8
acitretin 9
ACTEMRA INTRAVENOUS* 10
ACTIMMUNE 11
ACTOPLUS MET XR 12
ACURA BLOOD GLUCOSE TEST 13
ACUVAIL 14
adapalene external lotion 15
ADCIRCA 16
adefovir dipivoxil 17
ADVAIR DISKUS 18
ADVAIR HFA 19
ADVANCE INTUITION METER 20
ADVANCE INTUITION TEST 21
ADVATE 22
ADVICOR ORAL TABLET EXTENDED RELEASE 24 HR* 1000-20 MG 23
ADVICOR ORAL TABLET EXTENDED RELEASE 24 HR* 1000-40 MG, 500-20 MG 25
ADVICOR ORAL TABLET EXTENDED RELEASE 24 HR* 750-20 MG 24
ADVOCATE BLOOD GLUCOSE MONITOR 26
ADVOCATE DUO DEVICE 27
ADVOCATE REDI-CODE DEVICE 28
ADVOCATE REDI-CODE IN VITRO 29
ADVOCATE REDI-CODE+ 30
ADVOCATE REDI-CODE+ TEST 31
ADVOCATE TEST 32
adynovate 33
AFEDITAB CR ORAL TABLET EXTENDED RELEASE 24 HR* 30 MG 35
AFEDITAB CR ORAL TABLET EXTENDED RELEASE 24 HR* 60 MG 34
AFINITOR 36
AGAMATRIX AMP TEST 37
AGAMATRIX JAZZ TEST 38
AGAMATRIX KEYNOTE TEST 39
AGAMATRIX PRESTO PRO METER 40
AGAMATRIX PRESTO TEST 41
AKYNZEO 42
ALDURAZYME 43
alendronate sodium oral tablet 10 mg, 40 mg, 5 mg 44
alendronate sodium oral tablet 70 mg, 35 mg 45
alfuzosin hcl er 46
ALIMTA 47
almotriptan malate 48
alogliptin benzoate 49
alogliptin-metformin hcl 50
alogliptin-pioglitazone 51
ALOXI INTRAVENOUS* SOLUTION 0.25 MG/5ML 52
ALPHANATE/VWF COMPLEX/HUMAN 53
ALPHANINE SD 54
alprazolam er 55
alprazolam xr 56
ALPROLIX 57
ALTAVERA 58
ALTOPREV 59
ALVESCO 60
alyacen 1/35 61
AMETHIA 62
AMETHIA LO 63
AMETHYST 64
AMITIZA 65
amlodipine besylate-valsartan 66
AMNESTEEM 67
amphetamine salt combo 68
amphetamine-dextroamphet er 69
amphetamine-dextroamphetamine 71
AMPYRA 72
ANDRODERM TRANSDERMAL PATCH 24 HR 2 MG/24HR, 4 MG/24HR 73
ANDROGEL PUMP TRANSDERMAL GEL 12.5 MG/ACT (1%) 78
ANDROGEL PUMP TRANSDERMAL GEL 20.25 MG/ACT (1.62%) 79
ANDROGEL TRANSDERMAL GEL 20.25 MG/1.25GM (1.62%) 75
ANDROGEL TRANSDERMAL GEL 25 MG/2.5GM (1%) 76
ANDROGEL TRANSDERMAL GEL 40.5 MG/2.5GM (1.62%) 74
ANDROGEL TRANSDERMAL GEL 50 MG/5GM (1%) 77
ANZEMET ORAL 80
APIDRA 81
APIDRA SOLOSTAR SUBCUTANEOUS* 82
APRI 83
APRISO 84

ARALAST NP ... 85
ARANELLE ... 86
ARANESP (ALBUMIN FREE) INJECTION ... 87
ARANESP (ALBUMIN FREE) INJECTION ... 88
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 150 MCG/0.75ML, 10 MCG/0.4ML, 60 MCG/ML, 100 MCG/ML, 200 MCG/ML ... 87
ARCALYST ... 89
ARCAPTA NEOHALER ... 90
aripiprazole oral solution ... 92
aripiprazole oral tablet ... 91
aripiprazole oral tablet dispersible ... 91
armodafinil oral tablet 150 mg, 200 mg, 250 mg ... 93
armodafinil oral tablet 50 mg ... 95
ARZERRA ... 97
ASCENSIA AUTODISC TEST ... 98
ASMANEX 120 METERED DOSES ... 99
ASMANEX 14 METERED DOSES ... 100
ASMANEX 30 METERED DOSES ... 101
ASMANEX 60 METERED DOSES ... 102
ASSURE 3 TEST ... 103
ASSURE 4 METER ... 104
ASSURE 4 TEST ... 105
ASSURE PLATINUM ... 106
ASSURE PLATINUM METER ... 107
ASSURE PRO BLOOD GLUCOSE METER ... 108
ASSURE PRO TEST ... 109
atorvastatin calcium oral ... 110
ATRIPLA ... 111
AUBAGIO ... 112
AVANDAMET ORAL TABLET 2-1000 MG ... 114
AVANDAMET ORAL TABLET 2-500 MG ... 113
AVANDIA ... 115
AVIANE ... 116
AVITA EXTERNAL CREAM ... 117
AVONEX ... 118
AVONEX PEN INTRAMUSCULAR* ... 119
AVONEX PREFILLED INTRAMUSCULAR* ... 120
AXIRON ... 121
AZILECT ... 122
AZOR ... 123
AZURETTE ... 124
balsalazide disodium ... 125
BALZIVA ... 126
BANZEL ORAL SUSPENSION ... 128
BANZEL ORAL TABLET ... 127
BARACLUDE ORAL TABLET ... 129
BAYER BREEZE 2 TEST ... 130
BAYER CONTOUR MONITOR DEVICE ... 131
BAYER CONTOUR NEXT TEST ... 132
BAYER CONTOUR TEST ... 133
BEBULIN ... 134
BEBULIN VH ... 135
BECONASE AQ ... 136
BENICAR ... 137
BENICAR HCT ... 138
BENLYSTA ... 139
BETASERON SUBCUTANEOUS* KIT ... 140
bexarotene ... 141
BG STAR TEST ... 142
bicalutamide ... 143
bimatoprost ophthalmic ... 144
BIVIGAM ... 145
BOSULIF ORAL TABLET 100 MG ... 146
BOSULIF ORAL TABLET 500 MG ... 147
BOTOX ... 148
BRAVELLE ... 149
BREEZE 2 BLOOD GLUCOSE SYSTEM ... 150
BREVICON (28) ... 151
briellyn ... 152
BRILINTA ... 153
BROVANA ... 154
budesonide inhalation ... 155
BUNAVAIL ... 156
BUPHENYL ORAL TABLET ... 158
buprenorphine hcl sublingual tablet sublingual 2 mg ... 161
buprenorphine hcl sublingual tablet sublingual 8 mg ... 159
buprenorphine hcl-naloxone hcl ... 163
BUPROBAN ... 165
bupropion hcl er (smoking det) ... 167
bupropion hcl er (sr) ... 168
bupropion hcl er (xl) ... 169
bupropion hcl oral ... 166
butorphanol tartrate nasal ... 170
BUTRANS TRANSDERMAL PATCH WEEKLY 20 MCG/HR, 10 MCG/HR, 5 MCG/HR ... 171
BYDUREON SUBCUTANEOUS* SUSPENSION RECONSTITUTED ... 172
BYETTA 10 MCG PEN SUBCUTANEOUS* ... 173
BYETTA 5 MCG PEN SUBCUTANEOUS* ... 174
BYSTOLIC ORAL TABLET 2.5 MG, 5 MG, 10 MG ... 176
BYSTOLIC ORAL TABLET 20 MG ... 175
calcipotriene external ... 177
calcipotriene-betameth diprop ... 178

calcitonin (salmon) 179
CALCITRENE 180
CAMILA 181
CAMRESE 182
CAMRESE LO 183
CANASA 184
candesartan cilexetil oral tablet 4 mg, 8 mg, 16 mg 185
candesartan cilexetil-hctz 186
capecitabine 187
CAPRELSA ORAL TABLET 100 MG 188
CAPRELSA ORAL TABLET 300 MG 189
CARBAGLU 190
CARDURA XL 191
CARESENS N GLUCOSE SYSTEM 192
CARESENS N GLUCOSE TEST 193
CARIMUNE NF INTRAVENOUS* SOLUTION RECONSTITUTED 6 GM, 12 GM 194
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 300 MG, 180 MG 195
CARTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG 196
CAYSTON 197
CAZIANT 198
cefixime 199
celecoxib oral 200
CERDELGA 201
CEREZYME INTRAVENOUS* SOLUTION RECONSTITUTED 400 UNIT 202
CESAMET 203
CESIA 204
CETROTIDE SUBCUTANEOUS* KIT 0.25 MG 205
cevimeline hcl 206
CHANTIX 207
CHANTIX CONTINUING MONTH PAK 208
CHANTIX STARTING MONTH PAK 209
CHATEAL 210
CHENODAL 211
*chorionic gonadotropin intramuscular** 212
CIALIS ORAL TABLET 5 MG 213
CIMZIA PREFILLED 215
CIMZIA STARTER KIT 216
CIMZIA SUBCUTANEOUS* KIT 2 X 200 MG 214
citalopram hydrobromide oral tablet 10 mg, 20 mg 217
citalopram hydrobromide oral tablet 40 mg 218
CLARAVIS 219
CLEVER CHEK AUTO-CODE 220
CLEVER CHEK AUTO-CODE SYSTEM 221
CLEVER CHEK AUTO-CODE TEST 222
CLEVER CHEK AUTO-CODE VOICE 223
CLEVER CHEK AUTO-CODE VOICE IN VITRO 224
CLEVER CHEK TEST 225
CLEVER CHOICE AUTO-CODE SYSTEM 226
CLEVER CHOICE AUTO-CODE TEST 227
CLEVER CHOICE MICRO TEST 228
CLEVER CHOICE MINI SYSTEM 229
CLIMARA PRO 230
clonidine hcl er 231
clopidogrel bisulfate 232
clozapine oral tablet 100 mg 234
clozapine oral tablet 200 mg 237
clozapine oral tablet 50 mg, 25 mg 233
clozapine oral tablet dispersible 100 mg 234
clozapine oral tablet dispersible 12.5 mg 236
clozapine oral tablet dispersible 150 mg, 200 mg 235
clozapine oral tablet dispersible 25 mg 233
COAGADEX 238
colchicine oral tablet 239
COLYTE WITH FLAVOR PACKS ORAL SOLUTION RECONSTITUTED 227.1 GM 240
COMBIPATCH 241
COMETRIQ (100 MG DAILY DOSE) 242
COMETRIQ (140 MG DAILY DOSE) 243
COMETRIQ (60 MG DAILY DOSE) 244
COMPLERA 245
CONTROL AST 246
CONTROL TEST 247
COPAXONE SUBCUTANEOUS* 20 MG/ML 249
COPAXONE SUBCUTANEOUS* 40 MG/ML 248
CORDRAN EXTERNAL TAPE 250
COREG CR 251
CORIFACT 252
COSOPT PF 253
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000 UNIT, 24000 UNIT, 3000-9500 UNIT, 6000 UNIT 254
CRINONE 255
CRYSELLE-28 256
CUVPOSA 257
CYCLAFEM 1/35 258
CYCLESSA 259
CYCLOSET 260
DACOGEN 261
DAKLINZA 262

DAKLINZA 263
DALIRESP 264
darifenacin hydrobromide er 265
DASETTA 1/35 266
DAYSEE 267
DAYTRANA 268
DEBLITANE 270
decitabine 271
DELZICOL 272
DENAVIR 273
DEPO-PROVERA INTRAMUSCULAR* SUSPENSION 150 MG/ML 274
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS* SUSPENSION 275
DESCOVY 276
desloratadine 277
DESOGEN 278
DEXCOM G4 PLATINUM RECEIVER 279
DEXCOM G4 PLATINUM SENSOR KIT 280
DEXCOM G4 PLATINUM TRANSMITTER 281
DEXCOM G4 SENSOR 282
DEXILANT 283
dexmethylphenidate hcl 285
dexmethylphenidate hcl er 286
dextroamphetamine sulfate er 290
dextroamphetamine sulfate oral solution 288
dextroamphetamine sulfate oral tablet 289
diazepam gel 291
diclofenac sodium transdermal gel 1 % 292
DIFICID 293
diltiazem cd oral capsule extended release 24 hour 120 mg, 180 mg 295
diltiazem cd oral capsule extended release 24 hour 240 mg 294
diltiazem hcl er beads oral capsule extended release 24 hour 180 mg, 300 mg, 360 mg, 120 mg, 420 mg 298
diltiazem hcl er beads oral capsule extended release 24 hour 240 mg 299
diltiazem hcl er coated beads oral capsule extended release 24 hour 240 mg 301
diltiazem hcl er coated beads oral capsule extended release 24 hour 300 mg, 180 mg, 120 mg, 360 mg 300
diltiazem hcl er oral capsule extended release 12 hour 120 mg 296
diltiazem hcl er oral capsule extended release 24 hour 180 mg, 120 mg 296
diltiazem hcl er oral capsule extended release 24 hour 240 mg 297
dilt-xr oral capsule extended release 24 hour 180 mg, 120 mg 302
dilt-xr oral capsule extended release 24 hour 240 mg 303
DIPENTUM 304
donepezil hcl oral tablet 10 mg 306
donepezil hcl oral tablet 23 mg 305
dronabinol 307
drospiren-eth estrad-levomefol 308
drospirenone-ethinyl estradiol oral tablet 3-0.03 mg 309
DULERA 310
duloxetine hcl oral capsule delayed release particles 20 mg 313
duloxetine hcl oral capsule delayed release particles 30 mg, 60 mg 311
duloxetine hcl oral capsule delayed release particles 40 mg 312
dutasteride 314
easy plus ii glucose system 315
easy plus ii glucose test 316
EASY STEP GLUCOSE MONITOR DEVICE 317
EASY STEP TEST 318
easy talk blood glucose system device 319
easy talk blood glucose test 320
EASY TOUCH TEST 321
easy trak blood glucose test 322
EASYGLUCO IN VITRO 323
EASYMAX 15 TEST 324
EASYMAX L BLOOD GLUCOSE DEVICE 325
EASYMAX N BLOOD GLUCOSE DEVICE 326
EASYMAX NG BLOOD GLUCOSE DEVICE 327
EASYMAX TEST 328
EASYMAX V BLOOD GLUCOSE DEVICE 329
EASYMAX V2 BLOOD GLUCOSE DEVICE 330
easyplus blood glucose test 331
EASYPRO PLUS IN VITRO 332
EDARBI 333
EDARBYCLOR 334
EDURANT 335
EFFIENT 336
EGRIFTA SUBCUTANEOUS* SOLUTION RECONSTITUTED 2 MG 337
ELAPRASE 338
ELELYSO 339
ELEMENT PLUS 340
ELEMENT TEST 341
ELIDEL 342

ELINEST 343
ELIQUIS 344
ELLA 345
ELOCTATE 346
EMBEDA 347
EMBRACE BLOOD GLUCOSE MONITOR 348
EMBRACE BLOOD GLUCOSE TEST 349
EMEND ORAL CAPSULE 125 MG, 80 MG, 40 MG 351
EMEND ORAL CAPSULE 80 & 125 MG 350
EMOQUETTE 352
EMSAM 353
EMTRIVA ORAL CAPSULE 354
ENBREL SUBCUTANEOUS* 25 MG/0.5ML 356
ENBREL SUBCUTANEOUS* 50 MG/ML 355
ENBREL SUBCUTANEOUS* KIT 355
ENBREL SURECLICK SUBCUTANEOUS* 357
ENDOMETRIN 358
ENJUVIA ORAL TABLET 0.9 MG, 0.45 MG, 0.625 MG, 0.3 MG 359
ENJUVIA ORAL TABLET 1.25 MG 360
enoxaparin sodium 361
ENPRESSE-28 362
entecavir oral tablet 1 mg 363
EPCLUSA 364
EPIDUO 365
EPIDUO FORTE 366
epinephrine injection 0.3 mg/0.3ml, 0.15 mg/0.15ml 367
EPIPEN 2-PAK INJECTION 368
EPOGEN INJECTION SOLUTION 3000 UNIT/ML, 20000 UNIT/ML, 4000 UNIT/ML, 10000 UNIT/ML, 2000 UNIT/ML 369
epoprostenol sodium 370
eprosartan mesylate 371
ERIVEDGE 372
ERRIN 373
escitalopram oxalate oral tablet 10 mg 375
escitalopram oxalate oral tablet 5 mg, 20 mg 374
esomeprazole magnesium 376
estradiol transdermal patch biweekly 379
estradiol transdermal patch weekly 378
estradiol-norethindrone acet 380
ESTROGEL 381
ESTROSTEP FE 382
eszopiclone 383
EVAMIST 384
EVENCARE + BLOOD GLUCOSE TEST 385
EVENCARE BLOOD GLUCOSE TEST 386
EVENCARE G2 MONITOR 387
EVENCARE G2 TEST 388
EVENCARE G3 MONITOR 389
EVENCARE G3 TEST 390
EVOLUTION AUTOCODE 392
EVOLUTION AUTOCODE IN VITRO 391
EXJADE 393
EXTAVIA SUBCUTANEOUS* KIT 394
EZ SMART BLOOD GLUCOSE TEST 395
EZ SMART MONITORING SYSTEM 396
EZ SMART PLUS GLUCOSE TEST 397
EZ SMART PLUS MONITORING SYS 398
FABRAZYME 399
FALMINA 400
famciclovir oral tablet 125 mg, 250 mg 401
famciclovir oral tablet 500 mg 402
FANAPT 403
FANAPT TITRATION PACK 404
felodipine er 405
FEMCON FE 406
FEMHRT LOW DOSE 407
FEMRING 408
fenofibrate micronized 411
fenofibrate oral 409
fenofibrate oral 410
fenofibric acid oral tablet 412
fentanyl 413
fentanyl 414
fentanyl citrate buccal 415
FERRIPROX 416
FIFTY50 GLUCOSE TEST 2.0 417
FIRAZYR 418
FIRST-PROGESTERONE VGS 100 419
FIRST-PROGESTERONE VGS 200 420
FIRST-PROGESTERONE VGS 25 421
FIRST-PROGESTERONE VGS 400 422
FIRST-PROGESTERONE VGS 50 423
FLEBOGAMMA DIF 424
FLOVENT DISKUS 425
FLOVENT HFA 426
flunisolide nasal solution 25 mcg/act (0.025%) 427
fluoxetine hcl oral capsule 10 mg 433
fluoxetine hcl oral capsule 20 mg 431
fluoxetine hcl oral capsule 40 mg 432
fluoxetine hcl oral capsule delayed release 429
fluoxetine hcl oral tablet 10 mg 430
fluoxetine hcl oral tablet 20 mg 428
fluvastatin sodium 434
fluvastatin sodium er 435
fluvoxamine maleate oral tablet 100 mg 437

fluvoxamine maleate oral tablet 25 mg, 50 mg 436
FOCALIN XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 35 MG, 25 MG 438
FOLLISTIM AQ 440
fondaparinux sodium 441
FORA D10 2-IN-1 MONITOR 442
FORA D10 BLOOD GLUCOSE TEST 443
FORA D15G 2-IN-1 MONITOR 444
FORA D15G BLOOD GLUCOSE TEST 445
FORA D20 2-IN-1 MONITOR 446
FORA D20 BLOOD GLUCOSE TEST 447
FORA G20 BLOOD GLUCOSE TEST 448
FORA G30A BLOOD GLUCOSE SYSTEM 449
FORA G30A BLOOD GLUCOSE TEST 450
FORA GD20 BLOOD GLUCOSE SYSTEM 451
FORA GD20 TEST 452
FORA V10 BLOOD GLUCOSE SYSTEM 453
FORA V10 BLOOD GLUCOSE TEST 454
FORA V12 BLOOD GLUCOSE SYSTEM 455
FORA V12 BLOOD GLUCOSE TEST 456
FORA V20 BLOOD GLUCOSE SYSTEM 457
FORA V20 BLOOD GLUCOSE TEST 458
FORA V30A BLOOD GLUCOSE SYSTEM DEVICE 459
FORA V30A BLOOD GLUCOSE TEST 460
FORACARE GD40 MONITOR 461
FORACARE GD40 TEST 462
FORACARE PREMIUM V10 463
FORACARE PREMIUM V10 TEST 464
FORADIL AEROLIZER 465
FORTEO SUBCUTANEOUS* SOLUTION 600 MCG/2.4ML 466
FORTESTA 467
FORTICAL 468
FOSAMAX PLUS D 469
FRAGMIN SUBCUTANEOUS* SOLUTION 5000 UNIT/0.2ML, 18000 UNT/0.72ML, 12500 UNIT/0.5ML, 2500 UNIT/0.2ML, 10000 UNIT/ML, 15000 UNIT/0.6ML 470
FRAGMIN SUBCUTANEOUS* SOLUTION 95000 UNIT/3.8ML, 7500 UNIT/0.3ML, 25000 UNIT/ML 471
FREESTYLE INSULINX TEST 472
FREESTYLE LITE 473
FREESTYLE LITE TEST 474
FREESTYLE TEST 475
frovatriptan succinate 476
gabapentin oral capsule 478
gabapentin oral tablet 477
GAMMAGARD 479
GAMMAGARD S/D LESS IGA 480
GAMMAKED 481
GAMMAPLEX INTRAVENOUS* SOLUTION 5 GM/100ML, 10 GM/200ML, 2.5 GM/50ML 482
GAMUNEX-C 483
ganirelix acetate 484
gatifloxacin ophthalmic 485
GATTEX 486
GAVILYTE-C 487
GAVILYTE-G 488
ge100 blood glucose test 489
GELNIQUE TRANSDERMAL GEL 10 % 490
GELNIQUE TRANSDERMAL GEL 3 (28) % (MG/ACT) 491
GENERESS FE 492
GIANVI 493
GIAZO 494
GILDAGIA 495
GILDESS 1.5/30 496
GILDESS 1/20 497
GILDESS FE 1.5/30 498
GILDESS FE 1/20 499
GILENYA 500
GILOTRIF 501
GLATOPA 502
GLUCAGEN DIAGNOSTIC 503
GLUCAGEN HYPOKIT 504
GLUCOCARD 01 BLOOD GLUCOSE DEVICE 505
GLUCOCARD 01 SENSOR PLUS 506
GLUCOCARD EXPRESSION TEST 507
GLUCOCARD VITAL TEST 508
GLUCOCARD X-SENSOR 509
GLUCOCOM BLOOD GLUCOSE MONITOR 510
GLUCOCOM TEST 511
GONAL-F 512
GONAL-F RFF 513
GONAL-F RFF PEN 514
GONAL-F RFF REDIJECT 515
GRALISE ORAL TABLET 300 MG 516
GRALISE ORAL TABLET 600 MG 517
GRALISE STARTER 518
granisetron hcl oral 519
guanfacine hcl er 520
GUARDIAN REAL-TIME SYSTEM PED 521
HALAVEN 522
HARVONI 523
HELIXATE FS 524

HEMOFIL M INTRAVENOUS* SOLUTION RECONSTITUTED 220-400 UNIT, 250 UNIT, 1000 UNIT, 1700 UNIT, 500 UNIT, 1501-2000 UNIT, 801-1500 UNIT, 401-800 UNIT 525
HEPSERA 526
HIZENTRA SUBCUTANEOUS* SOLUTION 10 GM/50ML, 1 GM/5ML, 4 GM/20ML, 2 GM/10ML 527
hm nicotine transdermal patch 24 hr 7 mg/24hr 528
HORIZANT ORAL TABLET EXTENDEDRELEASE* 300 MG 530
HORIZANT ORAL TABLET EXTENDEDRELEASE* 600 MG 529
HUMATE-P INTRAVENOUS* SOLUTION RECONSTITUTED 500-1200 UNIT, 1000-2400 UNIT, 250-600 UNIT 531
HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS* 40 MG/0.8ML 535
HUMIRA PEN SUBCUTANEOUS* 536
HUMIRA PEN-CROHNS STARTER SUBCUTANEOUS* 537
HUMIRA PEN-PSORIASIS STARTER SUBCUTANEOUS* 538
HUMIRA SUBCUTANEOUS* 10 MG/0.2ML 532
HUMIRA SUBCUTANEOUS* 20 MG/0.4ML 533
HUMIRA SUBCUTANEOUS* 40 MG/0.8ML 534
HYCAMTIN ORAL 539
*hydrocod polst-cpm polst er oral liquid extendedrelease** 540
hydromorphone hcl er 541
ibandronate sodium oral 542
ICLUSIG ORAL TABLET 15 MG 544
ICLUSIG ORAL TABLET 45 MG 543
ILARIS 545
imatinib mesylate oral tablet 100 mg 546
imatinib mesylate oral tablet 400 mg 547
imiquimod external 548
IMPLANON 549
INCRELEX 550
INFINITY BLOOD GLUCOSE TEST 551
INLYTA 552
INTELENCE ORAL TABLET 100 MG, 25 MG 553
INTELENCE ORAL TABLET 200 MG 554
INTRON A 555
INTROVALE 556
INVOKANA 557
ipratropium bromide nasal 558
irbesartan 559
irbesartan-hydrochlorothiazide 560
ISENTRESS ORAL TABLET 561
ISENTRESS ORAL TABLET CHEWABLE 562
ISTODAX 563
itraconazole oral 564
JAKAFI 566
JANUMET 567
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HR* 100-1000 MG, 50-500 MG 569
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HR* 50-1000 MG 568
JANUVIA 570
JENTADUETO 571
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HR* 2.5-1000 MG 572
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HR* 5-1000 MG 573
jevantique lo 574
JINTELI 575
JOLESSA 576
JOLIVETTE 577
JUNEL 1.5/30 578
JUNEL 1/20 579
JUNEL FE 1.5/30 580
JUNEL FE 1/20 581
JUXTAPID ORAL CAPSULE 20 MG 583
JUXTAPID ORAL CAPSULE 5 MG, 10 MG 584
JUXTAPID ORAL CAPSULE 60 MG, 40 MG, 30 MG 582
KADIAN ORAL CAPSULE EXTENDED RELEASE 24 HOUR 150 MG, 200 MG, 40 MG, 130 MG, 70 MG 585
KALYDECO ORAL TABLET 586
KARIVA 587
KELNOR 1/35 588
KEPIVANCE 589
ketoconazole oral 590
ketorolac tromethamine ophthalmic 591
ketorolac tromethamine oral 592
KINERET SUBCUTANEOUS* 593
KOATE-DVI 594
KOGENATE FS 595
KOGENATE FS BIO-SET 596
KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HR* 2.5-1000 MG 597

KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HR* 5-1000 MG, 5-500 MG ... 598
KORLYM ... 599
KOVALTRY ... 600
kroger blood glucose test ... 601
kroger premium glucose test ... 602
kroger test ... 603
KURVELO ... 604
KUVAN ORAL PACKET 500 MG ... 605
KUVAN ORAL TABLET SOLUBLE ... 605
LAMISIL ORAL PACKET 125 MG ... 606
LAMISIL ORAL PACKET 187.5 MG ... 607
lamotrigine er oral tablet extended release 24 hr 100 mg, 25 mg* ... 614
lamotrigine er oral tablet extended release 24 hr 200 mg* ... 611
lamotrigine er oral tablet extended release 24 hr 250 mg, 300 mg* ... 612
lamotrigine er oral tablet extended release 24 hr 50 mg* ... 613
lamotrigine oral tablet dispersible 100 mg, 200 mg ... 608
lamotrigine oral tablet dispersible 25 mg ... 610
lamotrigine oral tablet dispersible 50 mg ... 609
lansoprazole oral capsule delayed release ... 615
LANTUS ... 616
LANTUS SOLOSTAR SUBCUTANEOUS* ... 617
LARIN FE 1.5/30 ... 618
LASTACAFT ... 619
latanoprost ophthalmic ... 620
LATUDA ORAL TABLET 20 MG, 120 MG, 60 MG, 40 MG ... 621
LATUDA ORAL TABLET 80 MG ... 622
LEENA ... 623
leflunomide oral ... 624
LEMTRADA ... 625
LESSINA ... 626
LETAIRIS ... 627
LEUKINE INTRAVENOUS* ... 628
leuprolide acetate injection ... 629
levalbuterol tartrate hfa ... 630
levetiracetam er oral tablet extended release 24 hr 500 mg* ... 631
levetiracetam er oral tablet extended release 24 hr 750 mg* ... 632
levocetirizine dihydrochloride oral solution ... 634
levocetirizine dihydrochloride oral tablet ... 633
LEVONEST ... 635
levonorgest-eth estrad 91-day oral tablet 0.15-0.03 mg, 0.1-0.02 & 0.01 mg ... 636
levonorgestrel-ethinyl estrad oral tablet 0.15-30 mg-mcg ... 637
LEVORA 0.15/30 (28) ... 638
LIALDA ... 639
liberty blood glucose meter ... 640
liberty blood glucose monitor ... 641
LIBERTY NEXT GENERATION TEST ... 642
LIBERTY NXT GENERATION MONITOR ... 643
liberty test ... 644
lidocaine external ointment ... 645
lidocaine external patch 5 % ... 647
lidocaine-prilocaine external cream ... 648
lindane external lotion ... 650
linezolid oral suspension reconstituted ... 651
linezolid oral tablet ... 652
LINZESS ... 653
LIVALO ... 654
LO LOESTRIN FE ... 655
LOESTRIN FE 1.5/30 ... 656
LOESTRIN FE 1/20 ... 657
LOMEDIA 24 FE ... 658
LORYNA ... 659
LOSEASONIQUE ... 660
lovastatin ... 661
LOW-OGESTREL ... 662
LUMIGAN OPHTHALMIC SOLUTION 0.01 % ... 663
LUMIZYME ... 664
LUPANETA PACK ... 665
LUPRON DEPOT ... 666
LUPRON DEPOT-PED ... 667
LUTERA ... 668
LYRICA ... 669
LYZA ... 670
malathion external ... 671
marlissa ... 672
MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HR* 180 MG, 300 MG, 420 MG, 360 MG ... 673
MATZIM LA ORAL TABLET EXTENDED RELEASE 24 HR* 240 MG ... 674
MAXIMA BLOOD GLUCOSE TEST ... 675
medroxyprogesterone acetate intramuscular suspension* ... 676
meijer blood glucose test ... 677
meijer premium glucose test ... 678
memantine hcl oral tablet 10 mg, 5 mg ... 679
memantine hcl oral tablet 5 (28)-10 (21) mg ... 680
MENOPUR ... 681
MENOSTAR ... 682
mesalamine oral ... 683

METADATE ER ORAL TABLET EXTENDEDRELEASE* 20 MG 684
metaxalone oral tablet 400 mg 686
metformin hcl er (mod) 687
methamphetamine hcl 688
METHYLIN ORAL TABLET CHEWABLE 689
methylphenidate hcl er (cd) 701
methylphenidate hcl er (la) oral capsule extended release 24 hour 20 mg, 40 mg 703
methylphenidate hcl er (la) oral capsule extended release 24 hour 30 mg 705
methylphenidate hcl er oral tablet extended release 24 hr 27 mg, 18 mg, 54 mg* 693
methylphenidate hcl er oral tablet extended release 24 hr 36 mg* 700
methylphenidate hcl er oral tablet extendedrelease 10 mg, 20 mg* 696
methylphenidate hcl er oral tablet extendedrelease 27 mg, 18 mg, 54 mg* 694
methylphenidate hcl er oral tablet extendedrelease 36 mg* 698
methylphenidate hcl oral solution 10 mg/5ml 690
methylphenidate hcl oral solution 5 mg/5ml 691
methylphenidate hcl oral tablet 692
metoprolol succinate er oral tablet extended release 24 hr 100 mg, 50 mg* 709
metoprolol succinate er oral tablet extended release 24 hr 200 mg* 707
metoprolol succinate er oral tablet extended release 24 hr 25 mg* 708
MIACALCIN INJECTION 710
MICRODOT TEST 711
MICROGESTIN 1.5/30 712
MICROGESTIN 1/20 713
MICROGESTIN FE 1.5/30 714
MICROGESTIN FE 1/20 715
MIMVEY 716
MIRCETTE 717
MIRENA (52 MG) 718
mirtazapine oral 719
modafinil 720
MODICON (28) 722
MONOCLATE-P 723
MONO-LINYAH 724
montelukast sodium oral 725
montelukast sodium oral 726
morphine sulfate er beads oral capsule extended release 24 hour 90 mg, 120 mg, 75 mg, 45 mg 728
morphine sulfate er oral capsule extended release 24 hour 727
MOZOBIL 729
MULTAQ 730
MYGLUCOHEALTH TEST 731
MYOBLOC 732
MYORISAN ORAL CAPSULE 20 MG, 40 MG, 10 MG 733
MYRBETRIQ 734
MYTESI 735
MYZILRA 736
naftifine hcl 737
NAFTIN EXTERNAL GEL 1 % 738
NAGLAZYME 739
naratriptan hcl 740
NATAZIA 741
NECON 0.5/35 (28) 742
NECON 1/35 (28) 743
NECON 1/50 (28) 744
NECON 10/11 (28) 745
NEULASTA DELIVERY KIT SUBCUTANEOUS* 747
NEULASTA SUBCUTANEOUS* 746
NEUPOGEN INJECTION 748
NEUPOGEN INJECTION SOLUTION 480 MCG/1.6ML, 300 MCG/ML 748
NEUPRO 749
NEUTEK 2TEK GLUCOSE/PRESSURE 750
NEUTEK 2TEK TEST 751
nevirapine er oral tablet extended release 24 hr 100 mg* 752
nevirapine er oral tablet extended release 24 hr 400 mg* 753
NEXAVAR 754
NEXIUM 24HR ORAL CAPSULE DELAYED RELEASE 757
NEXIUM ORAL PACKET 755
NEXPLANON 758
NEXT CHOICE ONE DOSE 759
NICODERM CQ 760
nicotine step 1 762
nicotine step 2 763
nicotine step 3 764
nicotine transdermal patch 24 hr 761
NICOTROL 765
NICOTROL NS 766
NIFEDIAC CC ORAL TABLET EXTENDED RELEASE 24 HR* 30 MG 767
NIFEDIAC CC ORAL TABLET EXTENDED RELEASE 24 HR* 60 MG 768
NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HR* 30 MG 769
NIFEDICAL XL ORAL TABLET EXTENDED RELEASE 24 HR* 60 MG 770

nifedipine er oral tablet extended release 24 hr 30 mg, 90 mg* 771
nifedipine er oral tablet extended release 24 hr 60 mg* 772
nifedipine er osmotic release oral tablet extended release 24 hr 60 mg* 774
nifedipine er osmotic release oral tablet extended release 24 hr 90 mg, 30 mg* 773
NIKKI 775
nisoldipine er oral tablet extended release 24 hr 20 mg, 25.5 mg, 40 mg, 8.5 mg, 17 mg, 34 mg* 776
nisoldipine er oral tablet extended release 24 hr 30 mg* 777
nitroglycerin translingual solution 778
NORA-BE 779
norethindrone oral 780
NORINYL 1+35 (28) 781
NORINYL 1+50 (28) 782
NORLYROC 783
NORTREL 0.5/35 (28) 784
NORTREL 1/35 (21) 785
NORTREL 1/35 (28) 786
NOVA MAX BLOOD GLUCOSE SYSTEM DEVICE 787
NOVA MAX GLUCOSE TEST 788
NOVAREL 789
NOVOEIGHT 790
NOVOLIN 70/30 791
NOVOLIN 70/30 RELION 792
NOVOLIN N 793
NOVOLIN N RELION 794
NOVOLIN R 795
NOVOLIN R RELION 796
NOVOLOG 797
NOVOLOG FLEXPEN SUBCUTANEOUS* 798
NOVOLOG MIX 70/30 799
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS* 800
NOVOLOG PENFILL SUBCUTANEOUS* 801
NOVOSEVEN 802
NOVOSEVEN RT 803
NOXAFIL ORAL SUSPENSION 804
NUCYNTA 805
NUCYNTA ER 806
NUEDEXTA 807
NULOJIX 808
NUVARING 809
NUWIQ 810
OCELLA 811
OCTAGAM INTRAVENOUS* SOLUTION 1 GM/20ML, 10 GM/200ML, 2 GM/20ML, 20 GM/200ML, 2.5 GM/50ML, 25 GM/500ML, 5 GM/100ML 812
octreotide acetate injection solution 500 mcg/ml, 100 mcg/ml, 1000 mcg/ml, 50 mcg/ml, 200 mcg/ml 813
ODEFSEY 814
OGESTREL 815
olanzapine oral tablet 10 mg, 15 mg, 20 mg, 5 mg, 7.5 mg 816
olanzapine oral tablet 2.5 mg 817
olanzapine oral tablet dispersible 816
olanzapine-fluoxetine hcl 818
OLEPTRO 819
omega-3-acid ethyl esters 820
omeprazole-sodium bicarbonate oral capsule 20-1100 mg 821
OMNARIS 822
OMNITROPE 823
ON CALL PLUS BLOOD GLUCOSE 824
ON CALL VIVID BLOOD GLUCOSE 825
ondansetron 826
ondansetron hcl oral solution 828
ondansetron hcl oral tablet 24 mg, 4 mg 829
ondansetron hcl oral tablet 8 mg 827
ONETOUCH TEST 830
ONETOUCH ULTRA BLUE 831
ONETOUCH VERIO IN VITRO STRIP 832
ONFI ORAL SUSPENSION 833
ONFI ORAL TABLET 10 MG, 20 MG 834
ONGLYZA 835
OPANA ER ORAL 836
OPSUMIT 837
OPTIUM TEST 838
OPTIUMEZ TEST 839
ORAVIG 840
ORENCIA CLICKJECT 843
ORENCIA INTRAVENOUS* 842
ORENCIA SUBCUTANEOUS* 841
ORKAMBI 844
ORKAMBI 845
ORSYTHIA 846
ORTHO MICRONOR 847
ORTHO TRI-CYCLEN (28) 848
ORTHO TRI-CYCLEN LO 849
ORTHO-CEPT (28) 850
ORTHO-CYCLEN (28) 851
ORTHO-NOVUM 1/35 (28) 852
ORTHO-NOVUM 7/7/7 (28) 853
OVCON-35 (28) 854

OVIDREL 855
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR* 150 MG, 300 MG 857
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HR* 600 MG 856
oxybutynin chloride er 859
oxybutynin chloride oral tablet 858
oxycodone-ibuprofen 860
OXYCONTIN ORAL 861
oxymorphone hcl 862
oxymorphone hcl er oral tablet extended release 12 hr 10 mg* 863
oxymorphone hcl er oral tablet extended release 12 hr 30 mg* 865
oxymorphone hcl er oral tablet extended release 12 hr 40 mg, 5 mg, 7.5 mg, 15 mg, 20 mg* 864
paliperidone er oral tablet extended release 24 hr 1.5 mg, 9 mg, 3 mg* 866
paliperidone er oral tablet extended release 24 hr 6 mg* 867
PANCREAZE ORAL CAPSULE DELAYED RELEASE PARTICLES 4200-10000 UNIT, 10500-25000 UNIT, 16800-40000 UNIT, 21000-37000 UNIT 868
pancrelipase (lip-prot-amyl) 869
PARAGARD INTRAUTERINE COPPER 870
paricalcitol oral 871
paroxetine hcl er oral tablet extended release 24 hr 25 mg* 874
paroxetine hcl er oral tablet extended release 24 hr 37.5 mg, 12.5 mg* 875
paroxetine hcl oral tablet 10 mg, 20 mg 872
paroxetine hcl oral tablet 30 mg, 40 mg 873
peg 3350/electrolytes 876
peg-3350/electrolytes 877
PEGASYS PROCLICK 879
PEGASYS SUBCUTANEOUS* SOLUTION 878
PEG-INTRON 880
PEG-INTRON REDIPEN 881
PEG-INTRON REDIPEN PAK 4 SUBCUTANEOUS* KIT 50 MCG/0.5ML, 150 MCG/0.5ML, 120 MCG/0.5ML 882
PENTASA ORAL CAPSULE EXTENDED RELEASE* 250 MG 883
PENTASA ORAL CAPSULE EXTENDED RELEASE* 500 MG 884
PERFOROMIST 885
PERTZYE 886
PHARMACIST CHOICE AUTOCODE 887
PHILITH 888
PICATO EXTERNAL GEL 0.015 % 890
PICATO EXTERNAL GEL 0.05 % 889
pioglitazone hcl 891
pioglitazone hcl-glimepiride 892
pioglitazone hcl-metformin hcl 893
PLAN B ONE-STEP 894
PLEGRIDY 895
PLEGRIDY STARTER PACK 896
POCKETCHEM EZ TEST 897
POMALYST 898
PORTIA-28 899
POTIGA ORAL TABLET 200 MG, 400 MG, 300 MG 900
POTIGA ORAL TABLET 50 MG 901
PRALUENT 902
pramipexole dihydrochloride er 903
pravastatin sodium 904
PRECISION PCX 905
PRECISION PCX PLUS TEST 906
PRECISION POINT OF CARE TEST 907
PRECISION QID TEST 908
PRECISION SOF-TACT TEST 909
PRECISION XTRA BLOOD GLUCOSE 911
PRECISION XTRA DEVICE 910
PRECISION XTRA MONITOR 912
PREFEST 913
PREGNYL 914
PREMARIN ORAL 915
PREMPHASE 916
PREMPRO 917
PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG 918
PREVIFEM 919
PREZISTA ORAL SUSPENSION 922
PREZISTA ORAL TABLET 600 MG, 75 MG, 150 MG 920
PREZISTA ORAL TABLET 800 MG 921
PRISTIQ 923
PRIVIGEN 924
PROAIR HFA 925
PROCRIT 926
PRODIGY AUTOCODE BLOOD GLUCOSE DEVICE 927
PRODIGY NO CODING BLOOD GLUC 928
PROFILNINE INTRAVENOUS* SOLUTION RECONSTITUTED 1000 UNIT 929
PROFILNINE SD 930
progesterone micronized oral 931
PROLASTIN-C INTRAVENOUS* SOLUTION RECONSTITUTED 1000 MG 932
PROLEUKIN 933

PROLIA 934
PROMACTA ORAL TABLET 25 MG, 12.5 MG, 50 MG 935
propafenone hcl er 936
PROVENTIL HFA 937
PULMICORT FLEXHALER 938
PULMOZYME 939
QNASL 940
QNASL CHILDRENS 941
QUASENSE 942
quetiapine fumarate oral tablet 100 mg, 50 mg 943
quetiapine fumarate oral tablet 200 mg 946
quetiapine fumarate oral tablet 25 mg 944
quetiapine fumarate oral tablet 300 mg, 400 mg 945
QUILLIVANT XR 947
quinine sulfate oral 949
ra blood glucose monitor 950
RA TRUETEST TEST 951
rabeprazole sodium 952
RAJANI 954
RANEXA 955
RAVICTI 956
REBETOL ORAL SOLUTION 957
REBIF REBIDOSE SUBCUTANEOUS* 959
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS* 960
REBIF SUBCUTANEOUS* 958
REBIF TITRATION PACK SUBCUTANEOUS* 961
RECLAST 962
RECLIPSEN 963
RECOMBINATE 964
RECTIV 965
REFUAH PLUS BLOOD GLUCOSE TEST 966
RELENZA DISKHALER 967
RELION CONFIRM/MICRO TEST 968
RELION PRIME MONITOR 969
RELION PRIME TEST 970
RELION ULTIMA TEST 971
RELISTOR SUBCUTANEOUS* SOLUTION 12 MG/0.6ML 972
RELISTOR SUBCUTANEOUS* SOLUTION 8 MG/0.4ML 973
RELPAX 974
REMICADE 975
REMODULIN 976
repaglinide-metformin hcl 977
REPATHA 978
REPATHA PUSHTRONEX SYSTEM 979
REPATHA SURECLICK 980
REPRONEX 981
RESCULA 982
REVEAL BLOOD GLUCOSE TEST 983
REVLIMID 984
REXALL BLOOD GLUCOSE TEST 985
REXULTI 986
REYATAZ ORAL CAPSULE 200 MG 987
REYATAZ ORAL CAPSULE 300 MG, 150 MG 988
RIASTAP 989
RIGHTEST GS100 BLOOD GLUCOSE 990
RIGHTEST GS300 BLOOD GLUCOSE 991
RIGHTEST GS550 BLOOD GLUCOSE 992
risedronate sodium oral tablet 150 mg 995
risedronate sodium oral tablet 5 mg, 30 mg, 35 mg 993
risedronate sodium oral tablet delayed release 994
RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 0.5 MG, 2 MG, 1 MG 999
RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 3 MG 1000
RISPERIDONE M-TAB ORAL TABLET DISPERSIBLE 4 MG 1001
risperidone oral tablet 1 mg, 0.25 mg, 0.5 mg, 2 mg 997
risperidone oral tablet 3 mg 998
risperidone oral tablet 4 mg 996
risperidone oral tablet dispersible 0.25 mg, 1 mg, 2 mg, 0.5 mg 997
risperidone oral tablet dispersible 3 mg 998
risperidone oral tablet dispersible 4 mg 996
RITUXAN INTRAVENOUS* SOLUTION 1002
rivastigmine 1003
rizatriptan benzoate 1004
ropinirole hcl er oral tablet extended release 24 hr 12 mg* 1006
ropinirole hcl er oral tablet extended release 24 hr 6 mg, 8 mg, 4 mg, 2 mg* 1005
rosuvastatin calcium 1007
ROZEREM 1008
SABRIL 1009
SABRIL 1010
SAFYRAL 1011
SAMSCA ORAL TABLET 15 MG 1013
SAMSCA ORAL TABLET 30 MG 1012
SANCUSO 1014
SAPHRIS 1015
SAPHRIS 1016
SAVELLA 1017

SAVELLA TITRATION PACK 1018
SEASONIQUE 1019
SELZENTRY 1020
SENSIPAR 1021
SEREVENT DISKUS 1022
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 150 MG, 200 MG 1023
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR* 300 MG, 400 MG, 50 MG 1024
sertraline hcl oral concentrate 1026
sertraline hcl oral tablet 100 mg 1028
sertraline hcl oral tablet 25 mg 1025
sertraline hcl oral tablet 50 mg 1027
SHAROBEL 1029
sildenafil citrate oral 1030
SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 500-40 MG, 1000-40 MG 1031
SIMCOR ORAL TABLET EXTENDED RELEASE 24 HR* 750-20 MG, 500-20 MG, 1000-20 MG 1032
SIMPONI ARIA 1034
SIMPONI SUBCUTANEOUS* 1033
SIMULECT 1035
simvastatin oral 1036
SMARTEST BLOOD GLUCOSE TEST 1037
SMARTEST EJECT 1038
SMARTEST PROTEGE 1039
sodium phenylbutyrate 1040
sodium phenylbutyrate oral powder 3 gm/tsp 1040
SOLIA 1041
SOLUS V2 TEST 1042
SOMATULINE DEPOT 1043
SOMAVERT 1044
SOVALDI 1045
SPIRIVA HANDIHALER 1046
SPIRIVA RESPIMAT INHALATION AEROSOL, SOLUTION 1.25 MCG/ACT 1047
SPORANOX ORAL SOLUTION 1048
SPRINTEC 28 1050
SPRYCEL ORAL TABLET 140 MG, 100 MG 1052
SPRYCEL ORAL TABLET 50 MG, 20 MG, 80 MG, 70 MG 1051
SRONYX 1053
STAVZOR 1054
STELARA INTRAVENOUS* 1055
STELARA SUBCUTANEOUS* 1056
STIMATE 1057
STIOLTO RESPIMAT 1058
STIVARGA 1059
STRATTERA 1060
STRIANT 1061
STRIBILD 1062
SUBOXONE SUBLINGUAL FILM 12-3 MG 1065
SUBOXONE SUBLINGUAL FILM 4-1 MG, 8-2 MG, 2-0.5 MG 1063
sulfasalazine oral 1067
SULFAZINE 1068
SULFAZINE EC 1069
sumatriptan nasal 1070
sumatriptan succinate oral 1073
*sumatriptan succinate refill subcutaneous** 1074
sumatriptan succinate subcutaneous 6 mg/0.5ml, 4 mg/0.5ml* 1072
sumatriptan succinate subcutaneous solution 4 mg/0.5ml* 1072
sumatriptan succinate subcutaneous solution 6 mg/0.5ml* 1071
SUPPRELIN LA 1075
SURE EDGE GLUCOSE MONITOR 1076
SURE EDGE TEST 1077
SURECHEK BLOOD GLUCOSE MONITOR DEVICE 1078
SURECHEK BLOOD GLUCOSE TEST 1079
SURESTEP PRO LINEARITY 1080
SURESTEP PRO TEST 1081
SURE-TEST EASYPLUS MINI METER 1082
SURE-TEST EASYPLUS MINI TEST 1083
SUTENT 1084
SYEDA 1085
SYLATRON SUBCUTANEOUS* KIT 300 MCG, 600 MCG, 4 X 300 MCG, 200 MCG, 4 X 200 MCG 1086
SYMBICORT 1087
SYMLINPEN 120 SUBCUTANEOUS* 1088
SYMLINPEN 60 SUBCUTANEOUS* 1090
SYNAGIS 1092
SYNRIBO 1093
TACLONEX EXTERNAL SUSPENSION 1094
TAKE ACTION 1095
TAMIFLU ORAL CAPSULE 1096
TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML 1097
TARCEVA 1098
TARGRETIN 1099
TASIGNA 1100
TAYTULLA 1101
TAZORAC 1102

TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 240 MG 1103
TAZTIA XT ORAL CAPSULE EXTENDED RELEASE 24 HOUR 300 MG, 360 MG, 180 MG, 120 MG 1104
TECHNIVIE 1105
TEKTURNA 1106
TEKTURNA HCT 1107
TELCARE BLOOD GLUCOSE TEST 1108
telmisartan 1109
telmisartan-amlodipine 1110
telmisartan-hctz 1111
temazepam oral capsule 7.5 mg, 22.5 mg 1112
temozolomide 1113
TESTIM 1114
TESTOPEL 1115
testosterone cypionate intramuscular solution 100 mg/ml* 1119
testosterone cypionate intramuscular solution 200 mg/ml* 1118
testosterone transdermal gel 10 mg/act (2%) 1117
testosterone transdermal gel 50 mg/5gm (1%), 12.5 mg/act (1%) 1116
tetrabenazine oral tablet 12.5 mg 1120
tetrabenazine oral tablet 25 mg 1121
TEVETEN HCT ORAL TABLET 600-25 MG 1122
tgt blood glucose test 1123
THALOMID 1124
tiagabine hcl oral tablet 2 mg 1126
tiagabine hcl oral tablet 4 mg 1125
TILIA FE 1127
TIROSINT 1128
tobramycin inhalation 1129
tolterodine tartrate 1130
tolterodine tartrate er 1131
topiramate oral capsule sprinkle 1132
TOVIAZ 1133
TRACLEER 1134
TRADJENTA 1135
tramadol hcl er (biphasic) 1137
tramadol hcl er oral tablet extended release 24 hr 1136
tramadol-acetaminophen 1138
tranexamic acid oral 1139
TRAVATAN Z 1140
tretinoin external 1141
TRETIN-X EXTERNAL CREAM 0.0375 % 1142
TRETTEN 1143
triamcinolone acetonide nasal aerosol† 1144
TRIBENZOR 1145
TRI-LEGEST FE 1146
TRI-LINYAH 1147
TRINESSA (28) 1148
TRI-NORINYL (28) 1149
TRI-PREVIFEM 1150
TRI-SPRINTEC 1151
TRIVORA (28) 1152
trospium chloride 1153
trospium chloride er 1154
TRUETEST TEST 1155
TRUETRACK TEST 1156
TRUVADA 1157
TRUVADA 1158
TUDORZA PRESSAIR INHALATION AEROSOL POWDER, BREATH ACTIVATED 400 MCG/ACT 1159
TUSSICAPS 1160
TYKERB 1161
TYZEKA 1162
UCERIS ORAL 1163
ULESFIA 1164
ULORIC 1165
ULTIMA TEST 1166
ULTRATRAK ACTIVE 1167
ULTRATRAK PRO 1168
ULTRATRAK PRO TEST 1169
ULTRATRAK ULTIMATE MONITOR 1170
ULTRATRAK ULTIMATE TEST 1171
ULTRESA 1172
VALCYTE 1173
valganciclovir hcl 1174
valsartan 1175
valsartan-hydrochlorothiazide 1176
VECTIBIX INTRAVENOUS* SOLUTION 400 MG/20ML, 100 MG/5ML 1177
VELCADE INJECTION 1178
VELIVET 1179
venlafaxine hcl er oral capsule extended release 24 hour 150 mg 1185
venlafaxine hcl er oral capsule extended release 24 hour 75 mg, 37.5 mg 1184
venlafaxine hcl oral tablet 100 mg, 25 mg 1181
venlafaxine hcl oral tablet 37.5 mg 1182
venlafaxine hcl oral tablet 50 mg 1180
venlafaxine hcl oral tablet 75 mg 1183
VERAMYST 1186
verapamil hcl er oral capsule extended release 24 hour 200 mg 1188
verapamil hcl er oral capsule extended release 24 hour 300 mg, 100 mg 1187

VESICARE 1189
VICTORY AGM-4000 TEST 1190
VICTORY BLOOD GLUCOSE SYSTEM 1191
VICTOZA SUBCUTANEOUS* 1192
VICTRELIS 1193
VIEKIRA PAK 1194
VIEKIRA XR 1195
VIIBRYD ORAL KIT 1197
VIIBRYD ORAL TABLET 1196
VIIBRYD ORAL TABLET 1198
VIIBRYD STARTER PACK 1199
VIMPAT ORAL TABLET 1200
VIOKACE 1201
viorele 1202
VIRAMUNE XR ORAL TABLET EXTENDED RELEASE 24 HR* 100 MG 1203
VIREAD ORAL TABLET 1204
VISTOGARD 1205
VOCAL POINT BLOOD GLUCOSE TEST 1206
voriconazole oral tablet 1207
VOTRIENT 1208
VPRIV 1209
VYTORIN 1210
VYVANSE 1211
WAVESENSE KEYNOTE PRO METER 1213
WAVESENSE PRESTO 1214
WELCHOL ORAL PACKET 1215
WERA 1216
WIDE-SEAL DIAPHRAGM 60 1217
WIDE-SEAL DIAPHRAGM 65 1218
WIDE-SEAL DIAPHRAGM 70 1219
WIDE-SEAL DIAPHRAGM 75 1220
WIDE-SEAL DIAPHRAGM 80 1221
WIDE-SEAL DIAPHRAGM 85 1222
WIDE-SEAL DIAPHRAGM 90 1223
WIDE-SEAL DIAPHRAGM 95 1224
WILATE INTRAVENOUS* KIT 1225
WYMZYA FE 1226
XALKORI 1227
XELJANZ 1228
XELJANZ XR 1229
XENAZINE ORAL TABLET 12.5 MG 1231
XENAZINE ORAL TABLET 25 MG 1230
XEOMIN 1232
XGEVA 1233
XIAFLEX 1234
XIFAXAN ORAL TABLET 200 MG 1236
XIFAXAN ORAL TABLET 550 MG 1235
XTANDI 1237
XULANE 1238
XURIDEN 1239
XYNTHA INTRAVENOUS* KIT 2000 UNIT, 1000 UNIT, 250 UNIT, 500 UNIT 1240
XYNTHA SOLOFUSE INTRAVENOUS* KIT 3000 UNIT 1241
XYREM 1242
YASMIN 28 1243
YAZ 1244
YERVOY 1245
zaleplon 1246
ZARAH 1247
ZAVESCA 1248
ZEGERID OTC 1249
ZELAPAR 1250
ZELBORAF 1251
ZEMAIRA 1252
ZENATANE 1253
ZENCHENT 1254
ZENCHENT FE 1255
ZEPATIER 1256
ZETIA 1257
ZETONNA 1258
ZIOPTAN 1259
ziprasidone hcl 1260
ZIRGAN 1261
zoledronic acid intravenous concentrate* 1262
zoledronic acid intravenous solution* 1262
ZOLINZA 1263
zolmitriptan oral 1264
zolpidem tartrate er 1266
zolpidem tartrate oral 1265
ZOMETA 1267
ZOMIG NASAL SOLUTION 5 MG 1268
ZOVIA 1/35E (28) 1269
ZOVIA 1/50E (28) 1270
ZOVIRAX EXTERNAL CREAM 1271
ZYTIGA 1272