

# Covered and non-covered drugs

**Drugs not covered — and their  
covered alternatives**

2019 Standard Formulary Exclusions Drug List

---

**aetna<sup>®</sup>**

Below is a list of medications that will not be covered without a prior authorization for medical necessity. If you continue using one of these drugs without prior approval, you may be required to pay the full cost. Ask your doctor to choose one of the generic or brand formulary options listed below.

Key	
UPPERCASE	Brand-name medicine
<i>lowercase italics</i>	Generic medicine

Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity <sup>1</sup>		Formulary Options
<b>Acromegaly</b>	SANDOSTATIN LAR		SOMATULINE DEPOT, SOMAVERT
<b>Allergies Nasal Steroids / Combinations</b>	BECONASE AQ OMNARIS	QNASL ZETONNA	<i>flunisolide spray, fluticasone spray, mometasone spray, triamcinolone spray, DYMISTA</i>
<b>Anticonvulsants</b>	ZONEGRAN		<i>carbamazepine, carbamazepine ext-rel, divalproex sodium, divalproex sodium ext-rel, gabapentin, lamotrigine, lamotrigine ext-rel, levetiracetam, levetiracetam ext-rel, oxcarbazepine, phenobarbital, phenytoin, phenytoin sodium extended, tiagabine, topiramate, valproic acid, zonisamide, FYCOMPA, OXTELLAR XR, TROKENDI XR, VIMPAT</i>
<b>Anti-infectives, Antibacterials Erythromycins / Macrolides</b>	E.E.S. GRANULES	ERYPED	<i>erythromycins</i>
<b>Anti-infectives, Antibacterials Tetracyclines</b>	MINOCIN		<i>minocycline</i>
	ACTICLATE DORYX	DORYX MPC TARGADOX	<i>doxycycline hyclate</i>
<b>Anti-infectives, Antibacterials Miscellaneous</b>	MACRODANTIN		<i>nitrofurantoin</i>
<b>Anti-infectives, Antivirals Cytomegalovirus *</b>	VALCYTE		<i>valganciclovir</i>
<b>Anti-infectives, Antivirals Hepatitis C *</b>	MAVYRET		EPCLUSA (genotypes 1, 2, 3, 4, 5, 6) HARVONI (genotypes 1, 4, 5, 6), VOSEVI <sup>2</sup>
	DAKLINZA TECHNIVIE VIEKIRA PAK	VIEKIRA XR ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6) HARVONI (genotypes 1, 4, 5, 6)
<b>Anti-infectives, Antivirals Herpes *</b>	VALTRES		<i>acyclovir, valacyclovir</i>
<b>Anti-inflammatory Steroidal, Ophthalmic</b>	PRED FORTE		<i>dexamethasone, prednisolone acetate 1%, DUREZOL, FLAREX, FML FORTE, FML S.O.P., MAXIDEX, PRED MILD</i>
<b>Antiobesity</b>	CONTRAVE	QSYMIA	BELVIQ, BELVIQ XR, SAXENDA

Aetna Pharmacy Management administers, but does not offer, insure or otherwise underwrite the prescription drug benefit portion of your health plan and has no financial responsibility therefor. Aetna Pharmacy Management refers to an internal business unit of Aetna Health Management, LLC. See coverage policy documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. This directory is applicable to both Aetna Commercial and joint venture plans.

<b>Category Drug Class</b>	<b>Drugs Requiring Prior Authorization for Medical Necessity <sup>1</sup></b>		<b>Formulary Options</b>
<b>Asthma * Beta Agonists, Short-Acting</b>	PROVENTIL HFA VENTOLIN HFA	XOPENEX HFA	<i>levalbuterol tartrate CFC-free aerosol</i> , PROAIR HFA, PROAIR RESPICLICK
<b>Asthma * Severe Asthma Agents</b>	FASENRA		NUCALA
<b>Asthma * Steroid Inhalants</b>	ALVESCO		ARNUITY ELLIPTA, ASMANEX, FLOVENT, PULMICORT FLEXHALER, QVAR, QVAR REDIHALER
<b>Asthma * or Chronic Obstructive Pulmonary Disease (COPD) * Steroid / Beta Agonist Combinations</b>	DULERA		ADVAIR, BREO ELLIPTA, SYMBICORT
<b>Attention Deficit Hyperactivity Disorder *</b>	ADDERALL XR		<i>amphetamine-dextroamphetamine mixed salts ext-rel, methylphenidate ext-rel</i> , MYDAYIS, VYVANSE
	INTUNIV		<i>amphetamine-dextroamphetamine mixed salts ext-rel, atomoxetine, guanfacine ext-rel, methylphenidate ext-rel</i> , MYDAYIS, VYVANSE
<b>Autoimmune Agents Ankylosing Spondylitis *</b>	CIMZIA	SIMPONI	COSENTYX, ENBREL, HUMIRA
<b>Autoimmune Agents Crohn's Disease *</b>	CIMZIA	ENTYVIO	HUMIRA, STELARA SUBCUTANEOUS (after failure of HUMIRA)
<b>Autoimmune Agents Psoriasis *</b>	CIMZIA COSENTYX	ENBREL	HUMIRA, OTEZLA, STELARA SUBCUTANEOUS, TALTZ
<b>Autoimmune Agents Psoriatic Arthritis *</b>	CIMZIA ORENCIA CLICKJECT ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS SIMPONI STELARA SUBCUTANEOUS TALTZ XELJANZ XELJANZ XR		COSENTYX, ENBREL, HUMIRA, OTEZLA
<b>Autoimmune Agents Rheumatoid Arthritis *</b>	ACTEMRA CIMZIA KINERET	ORENCIA INTRAVENOUS SIMPONI	ENBREL, HUMIRA, KEVZARA, ORENCIA CLICKJECT, ORENCIA SUBCUTANEOUS, XELJANZ, XELJANZ XR
<b>Autoimmune Agents Ulcerative Colitis *</b>	ENTYVIO	XELJANZ	HUMIRA, SIMPONI (after failure of HUMIRA)
<b>Autoimmune Agents All Other Conditions*</b>	ACTEMRA KINERET ORENCIA CLICKJECT ORENCIA INTRAVENOUS ORENCIA SUBCUTANEOUS		ENBREL, HUMIRA
<b>Cancer Chronic Myelogenous Leukemia *</b>	GLEEVEC	TASIGNA	<i>imatinib mesylate</i> , BOSULIF, SPRYCEL
<b>Cancer Prostate * Hormonal Agents, Antiandrogens</b>	NILANDRON		<i>bicalutamide</i> , XTANDI, ZYTIGA

<b>Category Drug Class</b>	<b>Drugs Requiring Prior Authorization for Medical Necessity <sup>1</sup></b>		<b>Formulary Options</b>
<b>Cancer Prostate * Hormonal Agents, Luteinizing Hormone-Releasing Hormone (LHRH) Agonists</b>	LUPRON DEPOT (For Prostate Cancer Only)		ELIGARD
<b>Cardiovascular Antiarrhythmics</b>	BETAPACE	BETAPACE AF	<i>sotalol</i>
<b>Cardiovascular Antilipemics Cholesterol Absorption Inhibitors</b>	ZETIA		<i>ezetimibe</i>
<b>Cardiovascular Antilipemics Fibrates</b>	TRICOR		<i>fenofibrate, fenofibric acid</i>
<b>Cardiovascular Antilipemics HMG-CoA Reductase Inhibitors (HMGs or Statins) / Combinations <sup>3</sup></b>	ALTOPREV CRESTOR LESCOL XL	LIPITOR LIVALO	<i>atorvastatin, ezetimibe-simvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin</i>
<b>Cardiovascular Antilipemics PCSK9 Inhibitors</b>	PRALUENT		REPATHA
<b>Cardiovascular Digitalis Glycosides</b>	LANOXIN TABLET (125 MCG and 250 MCG only)		<i>digoxin</i>
<b>Cardiovascular Diuretics</b>	DYRENIUM		<i>amiloride</i>
<b>Cardiovascular Pulmonary Arterial Hypertension * Phosphodiesterase Inhibitors</b>	ADCIRCA	REVATIO	<i>sildenafil</i>
<b>Carnitine Deficiency</b>	CARNITOR	CARNITOR SF	<i>levocarnitine</i>
<b>Chronic Obstructive Pulmonary Disease (COPD) * Anticholinergics</b>	TUDORZA		INCRUSE ELLIPTA, SPIRIVA
<b>Contraceptives Progestin Intrauterine Devices</b>	LILETTA		KYLEENA, MIRENA, SKYLA
<b>Cystic Fibrosis * Inhaled Antibiotics</b>	TOBI	TOBI PODHALER	<i>tobramycin inhalation solution, BETHKIS</i>
<b>Depression * Antidepressants, Selective Norepinephrine Reuptake Inhibitors (SNRIs)</b>	<i>venlafaxine ext-rel tablet (except 225 mg)</i> CYMBALTA EFFEXOR XR VENLAFAXINE EXT-REL TABLET (except 225 MG)		<i>desvenlafaxine ext-rel, duloxetine, venlafaxine, venlafaxine ext-rel capsule</i>

<b>Category Drug Class</b>	<b>Drugs Requiring Prior Authorization for Medical Necessity <sup>1</sup></b>		<b>Formulary Options</b>
<b>Depression *</b> <b>Antidepressants, Miscellaneous Agents</b>	OLEPTRO		<i>trazodone</i>
<b>Depression and/or Schizophrenia *</b> <b>Antipsychotics, Atypicals</b>	ABILIFY FANAPT	SEROQUEL XR	<i>aripiprazole, clozapine, olanzapine, quetiapine, quetiapine ext-rel, risperidone, ziprasidone, LATUDA, VRAYLAR</i>
<b>Dermatology Acne *</b>	ACANYA BENZACLIN ONEXTON	<i>vanoxide-HC</i> VELTIN ZIANA	<i>adapalene, benzoyl peroxide, clindamycin solution, clindamycin-benzoyl peroxide, erythromycin solution, erythromycin-benzoyl peroxide, tretinoin, ATRALIN, DIFFERIN, EPIDUO, RETIN-A MICRO, TAZORAC</i>
<b>Dermatology Actinic Keratosis *</b>	<i>fluorouracil cream 0.5%</i> CARAC		<i>fluorouracil cream 5%, fluorouracil solution, imiquimod, PICATO, TOLAK, ZYCLARA</i>
<b>Dermatology Antipsoriatics</b>	SORILUX		<i>calcipotriene</i>
<b>Dermatology Rosacea *</b>	NORITATE		<i>metronidazole, FINACEA, SOOLANTRA</i>
<b>Dermatology Skin Inflammation and Hives *</b> <b>Corticosteroids</b>	<i>clobetasol spray</i> CLOBEX SPRAY	OLUX-E	<i>clobetasol foam</i>
	APEXICON E		<i>desoximetasone, fluocinonide</i>
<b>Dermatology Wound Care Products</b>	ALEVICYN GEL ALEVICYN KIT	ALEVICYN SG <i>alevicyn solution</i>	<i>desonide, hydrocortisone</i>
<b>Dermatology Miscellaneous Skin Conditions</b>	ALCORTIN A BENSAL HP	NOVACORT SYNERDERM	<i>desonide, hydrocortisone</i>
<b>Diabetes *</b> <b>Biguanides</b>	FORTAMET GLUMETZA	RIOMET	<i>metformin, metformin ext-rel</i>
<b>Diabetes *</b> <b>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</b>	NESINA	ONGLYZA TRADJENTA	JANUVIA
<b>Diabetes *</b> <b>Dipeptidyl Peptidase-4 (DPP-4) Inhibitor Combinations</b>	JENTADUETO JENTADUETO XR KAZANO	KOMBIGLYZE XR OSENİ	JANUMET, JANUMET XR
<b>Diabetes *</b> <b>Injectable Incretin Mimetics</b>	BYDUREON BYETTA	TANZEUM	OZEMPIC, TRULICITY, VICTOZA

<b>Category Drug Class</b>	<b>Drugs Requiring Prior Authorization for Medical Necessity <sup>1</sup></b>		<b>Formulary Options</b>
<b>Diabetes *</b> <b>Insulins</b>	APIDRA	HUMALOG	FIASP, NOVOLOG
	HUMALOG MIX 50/50		NOVOLOG MIX 70/30
	HUMALOG MIX 75/25		NOVOLOG MIX 70/30
	HUMULIN 70/30 <sup>4</sup>		NOVOLIN 70/30 <sup>4</sup>
	HUMULIN N <sup>4</sup>		NOVOLIN N <sup>4</sup>
	HUMULIN R <sup>4</sup>		NOVOLIN R <sup>4</sup>
	NOTE: <i>Humulin R U-500 concentrate will not be subject to prior authorization and will continue to be covered.</i>		
<b>Diabetes *</b> <b>Long Acting Insulins</b>	LANTUS	TOUJEO	BASAGLAR, LEVEMIR, TRESIBA
<b>Diabetes *</b> <b>Insulin Sensitizers</b>	ACTOS		<i>pioglitazone</i>
<b>Diabetes *</b> <b>Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitors</b>	INVOKANA		FARXIGA, INVOKANA
<b>Diabetes *</b> <b>Sodium-Glucose Co-transporter 2 (SGLT2) Inhibitor / Biguanide Combinations</b>	INVOKAMET	INVOKAMET XR	SYNJARDY, SYNJARDY XR, XIGDUO XR
<b>Diabetes *</b> <b>Supplies, Needles <sup>5</sup></b>	NOVO NORDISK NEEDLES OWEN MUMFORD NEEDLES PERRIGO NEEDLES ULTIMED NEEDLES All other insulin needles that are not BD ULTRAFINE brand		BD ULTRAFINE NEEDLES
<b>Diabetes *</b> <b>Supplies, Syringes <sup>5</sup></b>	ALLISON MEDICAL INSULIN SYRINGES TRIVIDIA INSULIN SYRINGES ULTIMED INSULIN SYRINGES <i>All other insulin syringes that are not BD ULTRAFINE brand</i>		BD ULTRAFINE INSULIN SYRINGES
<b>Diabetes *</b> <b>Supplies, Test Strips and Kits <sup>6,7</sup></b>	BREEZE 2 STRIPS AND KITS CONTOUR NEXT STRIPS AND KITS CONTOUR STRIPS AND KITS FREESTYLE STRIPS AND KITS ONETOUCH ULTRA STRIPS AND KITS ONETOUCH VERIO STRIPS AND KITS All other test strips that are not ACCU-CHEK brand		ACCU-CHEK AVIVA PLUS STRIPS AND KITS <sup>6</sup> , ACCU-CHEK COMPACT PLUS STRIPS AND KITS <sup>6</sup> , ACCU-CHEK GUIDE STRIPS AND KITS <sup>6</sup> , ACCU-CHEK SMARTVIEW STRIPS AND KITS <sup>6</sup>
<b>Erectile Dysfunction *</b> <b>Phosphodiesterase Inhibitors</b>	STENDRA	VIAGRA	<i>sildenafil</i> , CIALIS
<b>Fertility *</b>	BRAVELLE	FOLLISTIM AQ	GONAL-F

<b>Category Drug Class</b>	<b>Drugs Requiring Prior Authorization for Medical Necessity <sup>1</sup></b>		<b>Formulary Options</b>
<b>Gastrointestinal Antiemetics</b>	ZUPLENZ		<i>granisetron, ondansetron, SANCUSO</i>
<b>Gastrointestinal Opioid-induced Constipation</b>	RELISTOR		MOVANTIK
<b>Gastrointestinal Proton Pump Inhibitors (PPIs)</b>	NEXIUM PREVACID	PROTONIX ZEGERID	<i>esomeprazole, lansoprazole, omeprazole, pantoprazole, DEXILANT</i>
<b>Gaucher Disease</b>	ELELYSO		CERDELGA, CEREZYME
<b>Genitourinary Interstitial Cystitis</b>	RIMSO-50		Consult doctor
<b>Growth Hormones</b>	GENOTROPIN NORDITROPIN NUTROPIN AQ	OMNITROPE SAIZEN	HUMATROPE
<b>Hematologic Anticoagulants (oral)</b>	PRADAXA		<i>warfarin, ELIQUIS, XARELTO</i>
<b>Hematologic Hemophilia A *</b>	ELOCTATE	HELIXATE FS	ADYNOVATE, JVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, NUWIQ
<b>Hematologic Hemophilia B *</b>	ALPROLIX		Consult doctor
<b>Hematologic Hereditary Angioedema *</b>	BERINERT		RUCONEST
<b>Hematologic Neutropenia Colony Stimulating Factors</b>	NEUPOGEN		ZARXIO
<b>Hematologic Platelet Aggregation Inhibitors</b>	PLAVIX		<i>clopidogrel, prasugrel, BRILINTA</i>
<b>High Blood Pressure * Angiotensin II Receptor Antagonists</b>	ATACAND BENICAR	DIOVAN EDARBI	<i>candesartan, eprosartan, irbesartan, losartan, olmesartan, telmisartan, valsartan</i>
<b>High Blood Pressure * Angiotensin II Receptor Antagonist / Diuretic Combinations</b>	ATACAND HCT BENICAR HCT	DIOVAN HCT EDARBYCLOR	<i>candesartan-hydrochlorothiazide, irbesartan- hydrochlorothiazide, losartan-hydrochlorothiazide, olmesartan-hydrochlorothiazide, telmisartan- hydrochlorothiazide, valsartan-hydrochlorothiazide</i>
<b>High Blood Pressure * Angiotensin II Receptor Antagonist / Calcium Channel Blocker Combinations</b>	EXFORGE		<i>amlodipine-olmesartan, amlodipine-telmisartan, amlodipine- valsartan</i>
<b>High Blood Pressure * Angiotensin II Receptor Antagonist / Calcium Channel Blocker / Diuretic Combinations</b>	EXFORGE HCT		<i>amlodipine-valsartan-hydrochlorothiazide, olmesartan- amlodipine-hydrochlorothiazide</i>

<b>Category Drug Class</b>	<b>Drugs Requiring Prior Authorization for Medical Necessity <sup>1</sup></b>		<b>Formulary Options</b>
<b>High Blood Pressure * Beta-blocker Combinations</b>	DUTOPROL		<i>metoprolol succinate ext-rel</i> <b>WITH</b> <i>hydrochlorothiazide</i>
<b>High Blood Pressure * Calcium Channel Blockers</b>	NORVASC		<i>amlodipine</i>
	CARDIZEM CARDIZEM CD CARDIZEM LA (and its generics) <i>matzim LA</i>		<i>diltiazem ext-rel</i> (except generic of CARDIZEM LA)
<b>Huntington's Disease</b>	XENAZINE		<i>tetrabenazine</i> , AUSTEDO
<b>Immunology Disease Modifying Antirheumatic Agents</b>	OTREXUP		RASUVO
<b>Inflammatory Bowel Disease (IBD) Ulcerative Colitis * Aminosalicylates</b>	ASACOL HD	DELZICOL	<i>balsalazide, sulfasalazine, sulfasalazine delayed-rel,</i> APRISO, LIALDA, PENTASA
	COLAZAL		<i>balsalazide</i>
<b>Interferons *</b>	PEGASYS		Consult doctor
<b>Kidney Disease * Phosphate Binders</b>	FOSRENOL		<i>calcium acetate, lanthanum carbonate, sevelamer carbonate,</i> PHOSLYRA, VELPHORO
<b>Multiple Sclerosis</b>	EXTAVIA		<i>glatiramer</i> , AUBAGIO, BETASERON, COPAXONE, GILENYA, REBIF, TECFIDERA, TYSABRI
<b>Musculoskeletal</b>	AMRIX		<i>cyclobenzaprine</i>
<b>Narcolepsy Wakefulness Promoters</b>	NUVIGIL		<i>armodafinil</i>
<b>Nephropathic Cystinosis</b>	PROCYSBI		CYSTAGON
<b>Ophthalmic Miscellaneous</b>	AVENOVA		Consult doctor
<b>Opioid Reversal</b>	EVZIO		<i>naloxone injection</i> , NARCAN NASAL SPRAY
<b>Osteoarthritis * Viscosupplements</b>	EUFLEXXA HYALGAN MONOVISC	ORTHOVISC SYNVISC SYNVISC-ONE	DUROLANE, GEL-ONE, GELSYN-3, SUPARTZ FX, VISCO-3
<b>Osteoporosis * Calcium Regulators</b>	MIACALCIN INJECTION		<i>alendronate, calcitonin-salmon, ibandronate, risedronate,</i> FORTEO, PROLIA, TYMLOS
	MIACALCIN NASAL SPRAY		<i>calcitonin-salmon</i>
<b>Overactive Bladder / Incontinence * Urinary Antispasmodics</b>	DETROL LA ENABLEX	OXYTROL	<i>darifenacin ext-rel, oxybutynin ext-rel, tolterodine,</i> <i>tolterodine ext-rel, trospium, trospium ext-rel,</i> MYRBETRIQ, TOVIAZ, VESICARE

The listed formulary options are subject to change.



<b>Category Drug Class</b>	<b>Drugs Requiring Prior Authorization for Medical Necessity <sup>1</sup></b>		<b>Formulary Options</b>
<b>Pain Headache *</b>	<i>butalbital- acetaminophen- caffeine capsule</i>	FIORICET CAPSULE VANATOL LQ VANATOL S	<i>diclofenac sodium, naproxen</i>
	CAFERGOT		<i>eletriptan, ergotamine-caffeine, naratriptan, rizatriptan, sumatriptan, zolmitriptan, ONZETRA XSAIL, ZEMBRACE SYMTOUCH, ZOMIG NASAL SPRAY</i>
<b>Pain Opioid Analgesics</b>	LAZANDA		<i>fentanyl transmucosal lozenge, ABSTRAL, SUBSYS</i>
	<i>levorphanol</i>		<i>fentanyl transdermal, hydromorphone ext-rel, methadone, morphine ext-rel, EMBEDA, HYSINGLA ER, NUCYNTA ER, OXYCONTIN</i>
	PRIMLEV		<i>hydrocodone-acetaminophen, hydromorphone, morphine, oxycodone-acetaminophen, NUCYNTA</i>
<b>Pain and Inflammation * Corticosteroids</b>	DEXPAK MILLIPRED	RAYOS	<i>dexamethasone, methylprednisolone, prednisolone solution, prednisone</i>
<b>Pain and Inflammation * Nonsteroidal Anti- inflammatory Drugs (NSAIDs) / Combinations</b>	ARTHROTEC		<i>celecoxib; diclofenac sodium, meloxicam or naproxen WITH esomeprazole, lansoprazole, omeprazole, pantoprazole, or DEXILANT</i>
	PENNSAID		<i>diclofenac sodium, diclofenac sodium gel 1%, diclofenac sodium solution, meloxicam, naproxen</i>
	CAMBIA INDOCIN	NAPRELAN SPRIX	<i>diclofenac sodium, meloxicam, naproxen</i>
<b>Postherpetic Neuralgia</b>	HORIZANT		<i>gabapentin, GRALISE</i>
<b>Prostate Condition Benign Prostatic Hyperplasia *</b>	JALYN		<i>doxazosin, dutasteride-tamsulosin; dutasteride or finasteride WITH alfuzosin ext-rel, tamsulosin, terazosin, RAPAFLO</i>
	UROXATRAL		<i>alfuzosin ext-rel, doxazosin, tamsulosin, terazosin, RAPAFLO</i>
<b>Pulmonary Enzyme Deficiency</b>	ZEMAIRA		ARALAST NP, GLASSIA, PROLASTIN-C
<b>Sleep Disorder Hypnotics, Non-benzodiazepines</b>	INTERMEZZO LUNESTA	ROZEREM ZOLPIMIST	<i>eszopiclone, zolpidem, zolpidem ext-rel, zolpidem sublingual, BELSOMRA, SILENOR</i>
<b>Testosterone Replacement * Androgens</b>	<i>testosterone gel 1% <sup>8</sup></i> ANDROGEL 1% FORTESTA	NATESTO TESTIM VOGELXO	<i>testosterone gel, testosterone solution, ANDRODERM, ANDROGEL 1.62%</i>
<b>Thyroid Supplements</b>	TIROSINT		<i>levothyroxine, SYNTHROID</i>
<b>Transplant * Immunosuppressants, Calcineurin Inhibitors</b>	PROGRAF		<i>tacrolimus</i>
<b>Urea Cycle Disorders</b>	BUPHENYL	RAVICTI	<i>sodium phenylbutyrate</i>

The listed formulary options are subject to change.

Drug Class	Formulary Options
<b>Autoimmune and Hepatitis C *</b>	For some clients, an Indication Based Formulary will be utilized for products in these classes and may result in additional products not covered without a medical exception.
<b>Drugs for infusion into spaces other than the blood</b>	A drug which must be infused into a space other than the blood will generally not be covered under the prescription drug benefit.
<b>Generics</b>	Limited source generics may be evaluated when appropriate and potentially not be covered without a medical exception.
<b>Hyperinflation</b>	On a quarterly basis, products with significant cost inflation that have clinically appropriate and more cost-effective alternatives may be evaluated and potentially not be covered without a medical exception.
<b>New-to-Market Agents <sup>1</sup></b>	New-to-market products and new variations of products already in the marketplace will not be added to the formulary immediately. Each product will be evaluated for clinical appropriateness and cost-effectiveness. Recommended additions to the formulary will be presented to the CVS Caremark® National Pharmacy and Therapeutics Committee (or other appropriate reviewing body) for review and approval.
<b>Specialty</b>	As new specialty products launch, as well as quarterly throughout the year, CVS Caremark will re-evaluate existing specialty products to determine appropriate formulary placement, which includes potentially not covering without a medical exception, adding back or deleting these products.

The listed formulary options are subject to change.

## List of Drugs Requiring Prior Authorization for Medical Necessity

### A

ABILIFY  
ACANYA  
ACTEMRA  
ACTICLATE  
ACTOS  
ADCIRCA  
ADDERALL XR  
ALCORTIN A  
ALEVICYN GEL  
ALEVICYN KIT  
ALEVICYN SG  
*alevicyn solution*  
ALLISON MEDICAL  
INSULIN SYRINGES <sup>5</sup>  
ALPROLIX  
ALTOPREV  
ALVESCO  
AMRIX  
ANDROGEL 1%  
APEXICON E  
APIDRA  
ARTHROTEC  
ASACOL HD  
ATACAND  
ATACAND HCT  
AVENOVA

### B

BECONASE AQ  
BENICAR  
BENICAR HCT  
BENSAL HP  
BENZACLIN  
BERINERT  
BETAPACE  
BETAPACE AF  
BRAVELLE  
BREEZE 2 STRIPS AND KITS <sup>7</sup>  
BUPHENYL  
*butalbital-acetaminophen-  
caffeine capsule*  
BYDUREON  
BYETTA

### C

CAFERGOT  
CAMBIA  
CARAC  
CARDIZEM  
CARDIZEM CD  
CARDIZEM LA  
(and its generics)  
CARNITOR  
CARNITOR SF  
CIMZIA  
*clobetasol spray*  
CLOBEX SPRAY  
COLAZAL  
CONTOUR NEXT STRIPS  
AND KITS <sup>7</sup>  
CONTOUR STRIPS AND KITS <sup>7</sup>  
CONTRAVE  
CRESTOR  
CYMBALTA

### D

DAKLINZA  
DELZICOL  
DETROL LA

DEXPAK  
DIOVAN  
DIOVAN HCT  
DORYX  
DORYX MPC  
DULERA  
DUTOPROL  
DYRENIUM

### E

EDARBI  
EDARBYCLOR  
E.E.S. GRANULES  
EFFEXOR XR  
ELELYSO  
ELOCTATE  
ENABLEX  
ENTYVIO  
ERYPED  
EUFLEXXA  
EVZIO  
EXFORGE  
EXFORGE HCT  
EXTAVIA

### F

FANAPT  
FASENRA  
FIORICET CAPSULE  
*fluorouracil cream 0.5%*  
FOLLISTIM AQ  
FORTAMET  
FORTESTA  
FOSRENOL  
FREESTYLE STRIPS AND KITS <sup>7</sup>

### G

GENOTROPIN  
GLEEVEC  
GLUMETZA

### H

HELIXATE FS  
HORIZANT  
HUMALOG  
HUMALOG MIX 50/50  
HUMALOG MIX 75/25  
HUMULIN 70/30 <sup>4</sup>  
HUMULIN N <sup>4</sup>  
HUMULIN R <sup>4</sup>  
HYALGAN

### I

INDOCIN  
INTERMEZZO  
INTUNIV  
INVOKAMET  
INVOKAMET XR  
INVOKANA

### J

JALYN  
JENTADUETO  
JENTADUETO XR

### K

KAZANO  
KINERET  
KOMBIGLYZE XR

### L

LANOXIN TABLET (125 MCG  
and 250 MCG only)  
LANTUS

LAZANDA  
LESCOL XL  
*levorphanol*  
LILETTA  
LIPITOR  
LIVALO  
LUNESTA  
LUPRON DEPOT

### M

MACRODANTIN  
*matzim LA*  
MAVRET  
MIACALCIN INJECTION  
MIACALCIN NASAL SPRAY  
MILLIPRED  
MINOCIN  
MONOVISC

### N

NAPRELAN  
NATESTO  
NESINA  
NEUPOGEN  
NEXIUM  
NILANDRON  
NORDITROPIN  
NORITATE  
NORVASC  
NOVACORT  
NOVO NORDISK NEEDLES <sup>5</sup>  
NUTROPIN AQ  
NUVIGIL

### O

OLEPTRO  
OLUX-E  
OMNARIS  
OMNITROPE  
ONETOUCH ULTRA  
STRIPS AND KITS <sup>7</sup>  
ONETOUCH VERIO  
STRIPS AND KITS <sup>7</sup>  
ONEXTON  
ONGLYZA  
ORENCIA INTRAVENOUS  
ORTHOVISC  
OSENI  
OTREXUP  
OWEN MUMFORD NEEDLES <sup>5</sup>  
OXYTROL

### P

PEGASYS  
PENNSAID  
PERRIGO NEEDLES <sup>5</sup>  
PLAVIX  
PRADAXA  
PRALUENT  
PRED FORTE  
PREVACID  
PRIMLEV  
PROCYSBI  
PROGRAF  
PROTONIX  
PROVENTIL HFA

### Q

QNASL  
QSYMIA

### R

RAVICTI  
RAYOS  
RELISTOR  
REVATIO  
RIMSO-50  
RIOMET  
ROZEREM

### S

SAIZEN  
SANDOSTATIN LAR  
SEROQUEL XR  
SORILUX  
SPRIX  
STENDRA  
SYNERDERM  
SYNVISC  
SYNVISC-ONE

### T

TANZEUM  
TARGADOX  
TASIGNA  
TECHNIVIE  
TESTIM  
*testosterone gel 1% <sup>8</sup>*  
TIROSINT  
TOBI  
TOBI PODHALER  
TOUJEO  
TRADJENTA  
TRICOR  
TRIVIDIA INSULIN SYRINGES <sup>5</sup>  
TUDORZA

### U

ULTIMED INSULIN SYRINGES <sup>5</sup>  
ULTIMED NEEDLES <sup>5</sup>  
UROXATRAL

### V

VALCYTE  
VALTRES  
VANATOL LQ  
VANATOL S  
*vanoxide-HC*  
VELTIN  
*venlafaxine ext-rel tablet*  
(except 225 mg)  
VENLAFAXINE EXT-REL TABLET  
(except 225 MG)  
VENTOLIN HFA  
VIAGRA  
VIEKIRA PAK  
VIEKIRA XR  
VOGELXO

### X

XENAZINE  
XOPENEX HFA

### Z

ZEGERID  
ZEMAIRA  
ZEPATIER  
ZETIA  
ZETONNA  
ZIANA  
ZOLPIMIST  
ZONEGRAN  
ZUPLENZ

\* This list indicates the common uses for which the drug is prescribed. Some drugs are prescribed for more than one condition.

- 1 If your doctor believes you have a specific clinical need for one of these products, he or she should contact the Prior Authorization department at: 1-855-240-0536.
- 2 For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3).
- 3 If approved for coverage and prescribed for primary prevention of cardiovascular disease, may be covered without cost sharing through an exceptions process.
- 4 Rebranded or private label formulations are not covered without a prior authorization for medical necessity (i.e., RELION).
- 5 BD ULTRAFINE syringes and needles are the only preferred options.
- 6 An ACCU-CHEK blood glucose meter may be provided at no charge by the manufacturer to those individuals currently using a meter other than ACCU-CHEK. For more information on how to obtain a blood glucose meter, call: 1-877-418-4746.
- 7 ACCU-CHEK brand test strips are the only preferred options.
- 8 Listing reflects the authorized generics for TESTIM and VOGELXO.

Please remember that this is not a complete list of medications covered under your plan. Because there are thousands of medications included in your pharmacy benefit, we only list the most common ones. Certain drugs, such as those for smoking cessation or vitamins, may not be covered by your particular pharmacy plan. Diabetic supplies may be covered under your medical plan. If you have any questions about your pharmacy benefits, please visit **aetna.com** and log in to your secure member website. If you don't have access to our website, call the toll-free number on your member ID card. To check coverage and copay information for a specific medicine, visit **aetna.com** and log in to your secure member website. For more details, please call the toll-free number on your member ID card.

This is not an inclusive list. Products that are not represented on this list may be subject to plan-specific copayment or coinsurance. Void where prohibited by law.

Specific prescription benefits plan design may not cover certain categories or may be subject to additional charges or restrictions, regardless of their appearance in this document.

The drugs on the Pharmacy Drug (formulary) Guide, Formulary Exclusions, Precertification, Quantity Limit and Step Therapy Lists are subject to change. Coverage for specialty drugs follows the CVS Caremark Advanced Control Specialty Formulary™ and is being used with permission from CVS Health and/or one of its affiliates.

Aetna may receive rebates, discounts and service fees from pharmaceutical manufacturers for certain listed products.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information. Information is believed to be accurate as of the production date; however, it is subject to change. For questions, please call the toll-free number on your member ID card.

