

Covered and non-covered drugs

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

2019 Standard Formulary Exclusions Drug List

aetna[®]

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 ¹		Formulary Options
Acromegaly	SANDOSTATIN LAR		SOMATULINE DEPOT, SOMAVERT
Allergies Nasal Steroids / Combinations	BECONASE AQ OMNARIS	QNASL ZETONNA	<i>flunisolide spray, fluticasone spray, mometasone spray, triamcinolone spray, DYMISTA</i>
Anticonvulsants	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>
Anti-infectives, Antibacterials Erythromycins / Macrolides	E.E.S. GRANULES	ERYPED	<i>erythromycins</i>
Anti-infectives, Antibacterials Tetracyclines	MINOCIN		<i>minocycline</i>
	ACTICLATE DORYX	DORYX MPC TARGADOX	<i>doxycycline hyclate</i>
Anti-infectives, Antibacterials Miscellaneous	MACRODANTIN		<i>nitrofurantoin</i>
Anti-infectives, Antivirals Cytomegalovirus *	VALCYTE		<i>valganciclovir</i>
Anti-infectives, Antivirals Hepatitis C *	MAVYRET		EPCLUSA (genotypes 1, 2, 3, 4, 5, 6) HARVONI (genotypes 1, 4, 5, 6), VOSEVI ²
	DAKLINZA TECHNIVIE VIEKIRA PAK	VIEKIRA XR ZEPATIER	EPCLUSA (genotypes 1, 2, 3, 4, 5, 6) HARVONI (genotypes 1, 4, 5, 6)
Anti-infectives, Antivirals Herpes *	VALTRES		<i>acyclovir, valacyclovir</i>
Anti-inflammatory Steroidal, Ophthalmic	PRED FORTE		<i>dexamethasone, prednisolone acetate 1%, DUREZOL, FLAREX, FML FORTE, FML S.O.P., MAXIDEX, PRED MILD</i>
Antiobesity	CONTRAIVE	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.

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

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

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

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

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

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

Category Drug Class	Drugs Requiring Prior Authorization for Medical Necessity ¹		Formulary Options
Pain Headache *	<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>
Pain Opioid Analgesics	LAZANDA		<i>fentanyl transmucosal lozenge, ABSTRAL, SUBSYS</i>
	<i>levorphanol</i>		<i>fentanyl transdermal, hydromorphone ext-rel, methadone, morphine ext-rel, EMBEDA, HYSINGLA ER, NUCYNТА ER, OXYCONTIN</i>
	PRIMLEV		<i>hydrocodone-acetaminophen, hydromorphone, morphine, oxycodone-acetaminophen, NUCYNТА</i>
Pain and Inflammation * Corticosteroids	DEXPAK MILLIPRED	RAYOS	<i>dexamethasone, methylprednisolone, prednisolone solution, prednisone</i>
Pain and Inflammation * Nonsteroidal Anti- inflammatory Drugs (NSAIDs) / Combinations	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>
Postherpetic Neuralgia	HORIZANT		<i>gabapentin, GRALISE</i>
Prostate Condition Benign Prostatic Hyperplasia *	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>
Pulmonary Enzyme Deficiency	ZEMAIRA		ARALAST NP, GLASSIA, PROLASTIN-C
Sleep Disorder Hypnotics, Non-benzodiazepines	INTERMEZZO LUNESTA	ROZEREM ZOLPIMIST	<i>eszopiclone, zolpidem, zolpidem ext-rel, zolpidem sublingual, BELSOMRA, SILENOR</i>
Testosterone Replacement * Androgens	<i>testosterone gel 1% ⁸</i> ANDROGEL 1% FORTESTA	NATESTO TESTIM VOGELXO	<i>testosterone gel, testosterone solution, ANDRODERM, ANDROGEL 1.62%</i>
Thyroid Supplements	TIROSINT		<i>levothyroxine, SYNTHROID</i>
Transplant * Immunosuppressants, Calcineurin Inhibitors	PROGRAF		<i>tacrolimus</i>
Urea Cycle Disorders	BUPHENYL	RAVICTI	<i>sodium phenylbutyrate</i>

The listed formulary options are subject to change.

Drug Class	Formulary Options
Autoimmune and Hepatitis C *	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.
Drugs for infusion into spaces other than the blood	A drug which must be infused into a space other than the blood will generally not be covered under the prescription drug benefit.
Generics	Limited source generics may be evaluated when appropriate and potentially not be covered without a medical exception.
Hyperinflation	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.
New-to-Market Agents ¹	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.
Specialty	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 ⁵
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 ⁷
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 ⁷
CONTOUR STRIPS AND KITS ⁷
CONTRACE
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 ⁷

G

GENOTROPIN
GLEEVEC
GLUMETZA

H

HELIXATE FS
HORIZANT
HUMALOG
HUMALOG MIX 50/50
HUMALOG MIX 75/25
HUMULIN 70/30 ⁴
HUMULIN N ⁴
HUMULIN R ⁴
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
MAVYRET
MIACALCIN INJECTION
MIACALCIN NASAL SPRAY
MILLIPRED
MINOCIN
MONOVISC

N

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

O

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

P

PEGASYS
PENNSAID
PERRIGO NEEDLES ⁵
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% ⁸
TIROSINT
TOBI
TOBI PODHALER
TOUJEO
TRADJENTA
TRICOR
TRIVIDIA INSULIN SYRINGES ⁵
TUDORZA

U

ULTIMED INSULIN SYRINGES ⁵
ULTIMED NEEDLES ⁵
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.

