These criteria apply to the following:			
✓ ACF	✓ BF	☐ MMT	✓ Aetna FI ACF
✓ ACFC	☐ VF	☐ Marketplace (MF)	✓ Aetna FI ACFC
✓ SF	☐ VFC	☐ Aetna SG ACA (Aetna Health Exchanges)	☐ Aetna FI SOO
✓ SFC		☐ Aetna IVL	

MEDICAL NECESSITY CRITERIA

DRUG CLASS	MEDICAL NECESSITY CRITERIA (NON COVERED DRUGS)

Status: CVS Caremark Criteria
Type: Medical Necessity Criteria

POLICY

COVERAGE CRITERIA

The requested drug will be covered with prior authorization when the following criteria are met:

- The patient cannot be switched to a formulary drug

AND

- The requested drug is being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)

AND

- The prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature

AND

- The patient has tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives. Documentation is required for approval

  OR

- The patient has a contraindication to all the alternatives. Documentation is required for approval

REFERENCES

N/A