Generic Substitution Pharmacy Authorization Guidelines

Guidelines for Coverage

The Pharmacy Prior Authorization department under the direction of the Aetna Better Health/Aetna Better Health Kids’ pharmacy director and chief medical officer or designated medical director is responsible for reviewing requests for exceptions to the generic substitution requirement.

Aetna Better Health/Aetna Better Health Kids may grant an exception to the generic substitution requirement upon review of documentation of adverse effects caused by the generic alternative. To request an exception, a practitioner/provider must fax to the Pharmacy Prior Authorization department a completed copy of the standard MedWatch form (the FDA-required form used to document and report adverse effects) that was submitted to the FDA. Narrow therapeutic index drugs do not require a prior authorization.

The request form must include the following information:
- The member’s name and identification number
- Prescribing practitioner/provider’s name, address, and telephone number
- Brand/generic name, strength, and directions for use of requested drug
- Member diagnosis
- Clinical information, as appropriate

Requests for exceptions will be reviewed by the Pharmacy Prior Authorization department. Criteria for reviewing exception requests include:
- Documented therapeutic failure of an equivalent generic drug
- Documented allergic reaction to a component of the generic product
- Documented adverse event attributed to a component of the generic product

If criteria for approval are met, the request will be approved, and the requesting practitioner will be notified no later than twenty-four (24) hours from receipt of the request, or sooner, if required by state regulatory requirements.

If criteria for approval are not met, the request will be reviewed by the Aetna Medicaid chief medical officer or designated medical director for medical necessity. If the request for exception is denied, the denial will be communicated to the prescribing practitioner/provider by fax no later than twenty-four (24) hours from receipt. Both the practitioner/provider and member will also be notified of the reason for denial and an explanation of the appeal process with instructions on how to request and expedited appeal.

---

1 NCQA HP 2018/2019 UM11 E1-5
2 Pennsylvania HealthChoices Agreement