AETNA BETTER HEALTH®
Non-Formulary Prior Authorization guideline for Tranexamic acid

Drugs Covered
- Tranexamic acid

Authorization guidelines
For patients 12 years if age or older, who meet all of the following:
- Premenopausal female with diagnosis of cyclic heavy menstrual bleeding (menstrual flow >7days)
- Trial and failure, intolerance or contraindication to oral NSAIDs
  - Trial and failure, intolerance or contraindication to ANY of the following:
    - oral combination contraceptives, oral progesterone, progesterone-containing IUD, or medroxyprogesterone depot
  - Patient does not have any of the following:
    - history of thrombosis or thromboembolism
    - concurrent use of combination hormonal contraception

OR
Tranexamic acid may also be authorized for the treatment of acute bleeding episodes in patients with hemophilia

Additional Information:
Tranexamic acid is NOT covered for members with the following criteria:
- Use not approved by the FDA; AND
- The use is unapproved and not supported by the literature or evidence as an accepted off-label use.

Approval Duration:
Initial Approval:
- 90 days for menstrual bleeding
- Indefinite for hemophilia

Renewal: Indefinite with documentation response

Quantity Limits:
- 30 tablets per 30 days for menstrual bleeding
- 84 tablets per 30 days for hemophilia

Last Review: 4/2017
Previous PARP Approval: 6/2016
Current PARP Approval: 10/2017
**Medically Necessary** — A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member’s family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

**References:**