AETNA BETTER HEALTH®

Prior Authorization guideline for Trial Dose Quantity Limits

Trial Dose Quantity Limits

- Antipsychotic Medications

Authorization guidelines

Aetna Better Health will require the first prescription of a new drug regimen in the identified drug classes be dispensed at no greater than 15 day supply for the first two fills at the prescribed dose. Exceptions to this quantity limit:

1. Member has a claims history indicating they have taken this same drug for at least 15 days within the previous 180 day period.

OR

2. Member is new to Aetna Better Health and was previously stabilized on this drug regimen.

OR

3. The member is unable due to transportation or mobility issues to reasonably return in two weeks for to refill their medications and this may risk adherence to therapy, Aetna Better Health will provide an override for the member to receive a full monthly fill.

Members who have filled a trial dose quantity of medication and persist with the treatment regimen may continue to fill the prescription at usual month quantity limit outlined by their prescription drug benefit.

Authorization and Limitations

Initial Approval: 1 year
Extended Approval: 3 years.

Additional Information:

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.

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- 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.