AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Global Exception Criteria	Page:	1 of 2
Effective Date:	6/12/2026	Last Review Date:	5/19/2026

Applies to:	☒Illinois	☒Florida Kids	☒Maryland
	☒Michigan	☒Pennsylvania Kids	☒Texas CHIP

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for medications utilizing the Global Exception Criteria under the patient's prescription drug benefit.

Description:

The intent of the criteria is to ensure that patients follow selection elements noted in labeling and/or practice guidelines to ensure appropriate utilization.

Applicable Drug List:

Reference Formulary

Policy/Guideline:

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

- The requested product is not being prescribed for an indication that is recognized as an excluded benefit by the applicable health plan's program (e.g., weight loss, erectile dysfunction, fertility, cosmetic, hair loss, medical foods)

AND

- The request is for a formulary product for more than the initial limit

  OR

- The patient is unable to take the required number of formulary alternatives (3) for the given diagnosis due to a trial and inadequate treatment response or intolerance, or a contraindication. Documentation is required for approval

  AND

  - If the request is for a combination product for which individual components are available at similar doses on formulary, then the patient must have had a trial and failure of the separate individual components due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient, **AND**
  - If the request is for a brand name product that has a generic available on formulary, then the patient must have had a trial and failure of the generic agent due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient, **AND**
  - If the request is for a product with an available alternative dosage form for the same active ingredient on formulary, then there must be a clinical reason why the patient is unable to take an applicable alternative formulary dosage form based on the patient's condition (e.g., age, indication)

OR

- The patient has a clinical condition or needs a specific dosage form for which there is no formulary alternative or the listed formulary alternatives are not recommended based on published guidelines or clinical literature OR the formulary alternatives will likely be ineffective or less effective for the patient OR the formulary alternatives will likely cause an adverse effect. Documentation is required for approval

AND

- The requested product 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

Approval Duration and Quantity Restrictions:

Approval: 12 months or appropriate duration for requested drug

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

N/A