

ACTHAR

Products Affected

- HP ACTHAR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple sclerosis AND patient is currently on a disease modifying drug (interferon beta 1a, peginterferon beta1a, interferon beta1b, glatiramer, natalizumab, mitoxatrone, dimethyl fumarate, teriflunomide, alemtuzumab) to control disease progression, OR has tried and failed, contraindicated or intolerant to all DMDs AND the patient has failed corticosteroid therapy within the last 30 days or has an FDA labeled contraindication to corticosteroid therapy.
Age Restrictions	for infantile spasms patient must be less than 24 months of age
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

ADCIRCA

Products Affected

- ADCIRCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent use of organic nitrate or guanylate cyclase stimulators (includes intermittent use)
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or Doppler echocardiogram if patient is unable to undergo a right heart catheterization AND Patient has tried and had an insufficient response to at least one other PAH agent (e.g., sildenafil) therapy.
Age Restrictions	18 years and older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concomitant administration with nitrates or nitric oxide donors (such as amyl nitrate) in any form. Concomitant administration with phosphodiesterase inhibitors, including specific PDE-5 inhibitors (such as sildenafil, tadalafil, or vardenafil) or non-specific PDE inhibitors (such as dipyridamole or theophylline). Pregnancy.
Required Medical Information	Diagnosis of pulmonary arterial hypertension (WHO group I) AND diagnosis was confirmed by right heart catheterization OR Patient has a diagnosis of chronic thromboembolic pulmonary hypertension (CTEPH, WHO group 4) AND patient has persistent or recurrent disease after surgical treatment (e.g., pulmonary endarterectomy) or has CTEPH that is inoperable AND female patients are enrolled in the ADEMPAS REMS program.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

ALIQOPA

Products Affected

- ALIQOPA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Follicular Lymphoma: Diagnosis of relapsed follicular lymphoma in patients who have received at least 2 prior systemic therapies
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of therapy

ALUNBRIG

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic, ALK positive non-small cell lung cancer and have progressed or are intolerant to crizotinib.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12/31/2018
Other Criteria	None

AMPYRA

Products Affected

- AMPYRA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute).
Required Medical Information	Diagnosis of multiple sclerosis. Patient must demonstrate sustained walking impairment, but with the ability to walk 25 feet (with or without assistance) prior to starting Ampyra.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	Initial - 3 months. Renewal - 12 months
Other Criteria	None

ARANESP

Products Affected

- ARANESP (ALBUMIN FREE)

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure
Required Medical Information	<p>Diagnosis Hgb ferritin EPO level and Tsats. Aranesp may be considered medically necessary when following criteria met for diagnosis of anemia associated with CKD nonmyeloid malignancies due to chemotherapy or myelodysplastic syndromes. Initial and maintenance requests must have iron stores evaluated (serum ferritin greater or equal to 100ng/mL and transferrin saturation greater or equal to 20%) and receive iron therapy if needed. Initial request: other causes of anemia ruled out and inadequate response to epoetin alfa for at least 2 consecutive months with appropriate dose adjustment. CKD and MDS: Must have Hb less than or equal to 10g/dL. MDS only: EPO level less than or equal to 500mUnits/mL. Chemo treated: Must have Hb less than 10g/dL (within last 4 wks) and anticipated need for greater or equal to 8 wks. Continuing Therapy- CKD: Current (within last 4 wks) Hb less than 12g/dL OR documented dose adjustment of therapy with corresponding Hb levels to indicate maintenance therapy. MDS (must meet ALL): No response after 6-8 wks of therapy (or after 3-4 months if 5Q deletion MDS on Revlimid) and after trial of concomitant g-csf discontinue DPO and consider other options response defined as 1.5g/dL rise in Hb or decrease in RBC transfusion requirement) AND current Hb less than or equal 12g/dL. Chemo treated (after first 4-6 wks): response of no less than 1g/dL increase in Hb levels in any prior use of DPO. There cannot be a documented failure on previous DPO with a similar regimen. The member must meet ALL of the</p>

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
 2018 Prior Authorization Criteria

PA Criteria	Criteria Details
	<p>following criteria:Current (within the last 4 wks) Hb level is low enough (or declining rapidly enough) to necessitate transfusion (and Hb less than11g/dL) DPO stopped if after 6-8 wks (assuming appropriate dose increase has been attempted in non-responders as per FDA approved label) not experienced greater or equal to1 g/dL rise in Hb (per ASCO guidelines 2007) AND DPO should not be continued after completion of myelosuppressive chemotherapy.</p>
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	3 months for chemo induced anemia and 6 months for CKD/MDS
Other Criteria	None

Formulary ID: 18317
 Last Updated: 10/18/2018
 Version: 20 - Effective: 11/01/2018

AUBAGIO

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Severe hepatic impairment. Current treatment with leflunomide. Patients who are pregnant or women of childbearing potential not using reliable contraception.
Required Medical Information	Diagnosis of relapsing forms of multiple sclerosis (e.g., relapsing-remitting MS or progressive-relapsing MS) OR patient has experienced a first clinical episode and has MRI features consistent with multiple sclerosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	For renewal, patient has experienced an objective response to therapy (i.e. no or slowed progression of disease)

AURYXIA

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	For the management of hyperphosphatemia in patients with chronic kidney disease on dialysis
Age Restrictions	18 years and older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

BCG

Products Affected

- *bcg vaccine*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

BEXAROTENE

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Patient must meet one of following criteria: received prior systemic therapy for CTCL OR advanced-stage MF (stage IIB, III or IV) or SS OR early-stage MF (stage IA, IB or IIA) with folliculotropic/large cell transformation OR early-stage MF (stage IA, IB or IIA) refractory to skin directed therapy.
Age Restrictions	None
Prescriber Restrictions	Oncologist
Coverage Duration	12/31/2018
Other Criteria	Definite diagnosis of cutaneous T-cell lymphoma (CTCL) AND refractory to any prior systemic therapy (such as methotrexate)

BOSUTINIB

Products Affected

- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Signed statement of diagnosis from the physician, hepatic panel and CBC, trial and failure of imatinib or dasatinib and documentation of a 90 day response OR newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia (Ph + CML)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

BRIVIACT

Products Affected

- BRIVIACT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of partial-onset seizures, member must have history of inadequate response, contraindication, or intolerance to levetiracetam prior to approval.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	MANTLE CELL LYMPHOMA (MCL) (1) Patient must have a diagnosis of MCL AND (2) Patient has tried one other therapy
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by, or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of therapy

CAPRELSA

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Congenital long QT syndrome
Required Medical Information	Diagnosis of medullary thyroid cancer (MTC), and disease is one of the following: A) unresectable, locally advanced, or B) metastatic AND one of the following: patient has symptomatic disease or patient has progressive disease.
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

CARIMUNE

Products Affected

- CARIMUNE NF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	<p>Diagnosis of a primary humoral immunodeficiency disorder such as: primary immunoglobulin deficiency syndrome X-linked immunodeficiency with hyperimmunoglobulin etc.). Documented hypogammaglobulinemia (IgG less than 600mg/dl) Idiopathic/Immune Thrombocytopenia Purpura. Diagnosis of Acute ITP with any of the following: Management of acute bleeding due to severe thrombocytopenia (platelets less than 30 000/uL) To increase platelet counts prior major surgical procedures Severe thrombocytopenia (platelets less than 20 000/uL) at risk for intracerebral hemorrhage. Diagnosis of Chronic ITP and ALL of the following are met: Prior treatment has included corticosteroids and splenectomy Duration of illness less than 6 months No concurrent illness explaining thrombocytopenia Platelets persistently at or below 20 000/uL. Chronic Lymphocytic Leukemia (CLL B-cell). With either of the following present: Hypogammaglobulinemia (IgG less than 600mg/dL) Recurrent bacterial infections associated with B-cell CLL. Kawasaki Disease. Diagnosed with Kawasaki Syndrome within ten days of onset of disease manifestations or is diagnosed after ten days of disease onset and continues to exhibit manifestations of inflammation or evolving coronary artery disease. IVIG is used in combination with high dose aspirin for the prevention of coronary artery aneurysms. Bone Marrow Transplant (BMT). Member is hypogammaglobinemic (IgG less than 400mg/dL). Hematopoietic Stem Cell Transplantation (HSCT). Is within first 100 days of allogenic hematopoietic stem cell transplantation. Is</p>

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
 2018 Prior Authorization Criteria

PA Criteria	Criteria Details
	<p>experiencing hypogammaglobulinemia (serum IgG level less than 400 mg/dL). AIDS/HIV. Has any of the following conditions: CD4+ T-cell counts greater than or equal 200/mm³ To prevent maternal transmission of HIV infection IVIG is used in conjunction with zidovudine to prevent serious bacterial infections in HIV-infected members who have hypogammaglobulinemia (serum IgG less than 400 mg/dL).</p>
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

Formulary ID: 18317
 Last Updated: 10/18/2018
 Version: 20 - Effective: 11/01/2018

EMEND

Products Affected

- *aprepitant*

- EMEND INTRAVENOUS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Fosaprepitant is contraindicated in patients with a hypersensitivity to aprepitant or any other component of the formulation concurrent use with cisapride or pimozone.
Required Medical Information	Emend IV (fosaprepitant) will require prior authorization. This agent may be considered medically necessary when the following criteria are met: Prophylaxis of Chemotherapy-induced nausea and vomiting due to moderately-highly emetogenic chemotherapy. Patient must be on concomitant corticosteroid and a 5HT3 agonist (ondansetron dolasetron palonosetron or granisetron) if no contraindication.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

EMPLICITI

Products Affected

- EMLICITI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of multiple myeloma and used in combination with lenalidomide and dexamethasone in patients who have received 1 to 3 prior therapies.
Age Restrictions	18 years and older
Prescriber Restrictions	Oncologist
Coverage Duration	12/31/2018
Other Criteria	None

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of acute sickle cell disease AND Must have A) trial history of Hydroxyurea OR B) intolerance to Hydroxyurea OR C) contraindication to Hydroxyurea
Age Restrictions	5 years of age and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

ENTRESTO

Products Affected

- ENTRESTO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Statement of diagnosis indicating Heart Failure (NYHA Class II-IV)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

ERLEADA

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of nonmetastatic, castration-resistant prostate cancer
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None

ERWINAZE

Products Affected

- ERWINAZE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

ESBRIET

Products Affected

- ESBRIET

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	1)Diagnosis of Idiopathic pulmonary fibrosis (IPF) as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF, AND 2) not used in combination with Ofev (nintedanib).
Age Restrictions	None
Prescriber Restrictions	Pulmonologist
Coverage Duration	12/31/2018
Other Criteria	None

ESRD THERAPY

Products Affected

- PROCRIT INJECTION SOLUTION
10000 UNIT/ML, 2000 UNIT/ML,
20000 UNIT/ML, 3000 UNIT/ML, 4000
UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Epoetin alfa therapy is not considered medically necessary for members with the following concomitant conditions: Concomitant use of another Recombinant Erythropoietin Product. Anemia in cancer not related to chemotherapy OR anemia associated only with radiotherapy (without chemo).ESAs are not indicated in cancer patients receiving myelosuppressive chemotherapy when the anticipated outcome is cure (ESAs remain indicated when myelosuppressive chemotherapy is intended for palliation.
Required Medical Information	Diagnosis Hgb ferritin EPO level Tsats. Epoetin alfa may be considered medically necessary when following criteria met for diagnosis of anemia associated with CKD Zidovudine-treated HIV-infected mbrs nonmyeloid malignancies due to chemo surgery myelodysplastic syndromes Hep C rheumatoid arthritis. Initial and maint requests except surgery use must have iron stores evaluated (ferritin greater or equal to 100ng/mL and Tsats greater or equal to 20%) and receive iron therapy if needed. CKD HIV MDS HCV:Must have Hb less or equal to 10g/dL.MDS and HIV:EPO level less or equal to 500mUnits/mL.HIV (intl / maint):Must receiving zidovudine and not exceed 4.2g/wk.HCV (intl / maint):Receiving combo IFN/RBV or PEGIFN/RBV. Chemo treated and RA:Must have Hb less than 10g/dL (within last 4 wks).Chemo treated: Need for greater than or equal to 8wks.RA (intl / maint):Receiving therapy known to cause anemia. Surg:elective noncardiace novascular surg with Hb greater than 10 less than or equal to 13g/dL.Maint

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

PA Criteria	Criteria Details
	<p>Therapy-CKD HIV HCV:Current Hb less than 12g/dL OR documented dose adj. of therapy with corresponding Hb levels to indicate maint therapy. HCV:Able to maintain previous RBV dosing without dose reduction dt anemia.RA:Current Hb less than11g/dL.MDS (must meet ALL):No response after 6-8 wks of therapy (or after 3-4 months if 5Q deletion MDS on Revlimid) and after trial of concomitant g-csf discontinue EPO and consider other options response defined as 1.5g/dL rise in Hb or decrease in RBC transfusion requirement AND current Hb less or equal to 12g/dL.Chemo treated (after first 4-6 wks): response of no less than 1g/dL increase in Hb levels in any prior use of EPO. Mbr must meet ALL :Current (within last 4 wks) Hb level is low enough to necessitate transfusion (and Hb less than11g/dL) EPO stopped if after 6-8 wks not experienced greater or equal to1g/dL rise in Hb AND EPO shouldn't be continued after completion of myelosuppressive chemotherapy.</p>
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	3 months
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Multiple Myeloma (MM) Used in combination with both of the following: Velcade (bortezomib) and dexamethasone. Patient has received at least two prior treatment regimens which included both of the following: Velcade (bortezomib) and an immunomodulatory agent [e.g., Revlimid (lenalidomide), Thalomid (thalidomide)].
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

FENTORA

Products Affected

- FENTORA BUCCAL TABLET 100 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- LAZANDA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Fentanyl Buccal Tablet (Fentora) may be considered medically necessary when the following criteria are met: The member is currently diagnosed with cancer OTFC is required to manage breakthrough pain member is currently taking opioid therapy and is opioid tolerant and member has tried and failed generic Actiq (fentanyl citrate lozenge). Tolerance is defined as any of the following: greater than or equal to 60mg morphine/day for greater than or equal than 1 week or greater than or equal to 50 mcg transdermal fentanyl/hour for greater than or equal 1 week or an equianalgesic dose of another opioid for greater than or equal 1 week.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

FLECTOR

Products Affected

- FLECTOR

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Previously experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs. Use for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery. Application to non-intact or damaged skin.
Required Medical Information	Patient is experiencing acute localized pain due to minor strains, sprains and contusions AND the intended duration of therapy is 3 months or less AND patient had experienced treatment failure with at least 2 prescription strength oral NSAIDs or patient has a documented swallowing disorder OR has a history of peptic ulcer disease/gastrointestinal bleeding OR patient is more than 65 years of age with one additional risk factor for gastrointestinal adverse event (e.g., use of anticoagulants or chronic corticosteroids)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

GILENYA

Products Affected

- GILENYA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Recent (within the last 6 months) occurrence of: myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure. History or presence of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a pacemaker. Baseline QTc interval greater than or equal to 500 ms. Receiving concurrent treatment with Class Ia or Class III anti-arrhythmic drugs (quinidine, procainamide, amiodarone, sotalol).
Required Medical Information	Diagnosis of a relapsing form of multiple sclerosis or diagnosis of first clinical episode with MRI features consistent with MS AND Patient will be observed for signs and symptoms of bradycardia in a controlled setting for at least 6 hours after the first dose
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	None

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician in patients with: 1) metastatic non-small cell lung cancer (NSCLC) whose tumors have non-resistant epidermal growth factor receptor (EGFR) mutations as detected by an FDA-approved test or 2) metastatic squamous NSCLC, progressing after platinum-based chemotherapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

GOCOVRI

Products Affected

- GOCOVRI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients with ESRD (CrCl below 15 ml/min/m ²)
Required Medical Information	INITIAL: Diagnosis of Parkinson's disease AND (1) Patient is experiencing dyskinesia AND (2) Patient is receiving levodopa based therapy AND (3) Must have documented trial and failure to amantadine immediate release. RENEWAL: (1) must meet the initial criteria above AND (2) Documentation of positive clinical response to Gocovri (e.g., decreased "off" periods, decreased "on" time with troublesome dyskinesia)
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None

GROWTH HORMONE

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Closed epiphyses. Acute critical illness due to complications following open heart or abdominal surgery, multiple accidental trauma or acute respiratory failure. Active malignancy. Active proliferative or severe non-proliferative diabetic retinopathy. For PWS only: severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment.
Required Medical Information	Diagnosis of pediatric indication: A) GHD and bone age at least 1 year or 2 standard deviations (SD) delayed compared with chronological age and 2 stim tests with peak GH secretion below 10 ng/mL or IGF-1/IGFBP3 level more than 2 SDS below mean if CNS pathology, h/o irradiation, or proven genetic cause, B) SGA and birth weight or length 2 or more SDS below mean for gestational age and fails to manifest catch up growth by age 2 (height 2 or more SDS below mean for age and gender), C) CRI and nutritional status has been optimized, metabolic abnormalities have been corrected, and patient has not had renal transplant D) SHOX deficiency or Noonan syndrome E) PWS confirmed by genetic testing, F) Turner Syndrome confirmed by chromosome analysis. For GHD, CRI, SHOX deficiency, Noonan syndrome, and PWS one of the following: height more than 3 SDS below mean for age and gender, or height more than 2 SDS below mean with GV more than 1 SDS below mean, or GV over 1 year 2 SDS below mean. OR Diagnosis of an adult indication: A) childhood- or adult-onset GHD confirmed by 2 standard GH stim tests (provide assay): 1 test must be insulin tolerance test (ITT) with blood glucose nadir less than 40 mg/dL (2.2 mmol/L). If contraindicated, use a standardized stim test (i.e. arginine plus GH releasing

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

PA Criteria	Criteria Details
	hormone [preferred], glucagon, arginine), B) GHD with at least 1 other pituitary hormone deficiency and failed at least 1 GH stim test (ITT preferred), C) GHD with panhypopituitarism (3 or more pituitary hormone deficiencies), D) GHD with irreversible hypothalamic-pituitary structural lesions due to tumors, surgery or radiation of pituitary or hypothalamus region AND a subnormal IGF-1 (after at least 1 month off GH therapy) AND Objective evidence of GHD complications, such as: low bone density, increased visceral fat mass, or cardiovascular complications AND Completed linear growth (GV less than 2 cm/year) AND GH has been discontinued for at least 1 month (if previously receiving GH).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

HEPATITIS C

Products Affected

- EPCLUSA
- HARVONI
- MAVYRET
- ZEPATIER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Must submit documentation of chronic hepatitis C genotype (confirmed by HCV RNA level within the last 6 months). Must submit laboratory results within 6 weeks of initiating therapy including: 1) CBC w Platelets, 2) AST/ALT, 3) Total Bilirubin, 4) Serum Albumin, 5) PT/INR, 6) Serum Creatinine, and 7) GFR. FOR GENOTYPES 1 and 4-Must include subtype, trial/failure, contraindication to, or intolerance to Zepatier or Mavyret prior to approval of Eplusa or Havoni. GENOTYPES 2 and 3-Must include subtype, trial/failure, contraindication to, or intolerance to Mavyret prior to approval of Eplusa. GENOTYPES 5 and 6-Must include subtype, trail/failure, contraindication to, or intolerance to Mavyret prior to approval of Eplusa or Harvoni.
Age Restrictions	None
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Duration of approval per AASLD Guidelines
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Non-24-hour-sleep-wake disorder (Non-24) AND patient has documented blindness
Age Restrictions	18 years of age or older
Prescriber Restrictions	None
Coverage Duration	6 months (initial), 12 months (renewal)
Other Criteria	For renewal, patient experienced an objective improvement (e.g., improvement in timing of nighttime sleep, improvement in duration of nighttime sleep, or reduction in daytime sleep).

HRM

Products Affected

- *guanfacine hcl er*
- *methylphenidate hcl*
- *methylphenidate hcl er*
- *methylphenidate hcl er (cd)*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Physician has documented the indication for the continued use of the HRM (high risk med) with an explanation of the specific benefit established with the medication and how that benefit outweighs the potential risk. AND The physician must document on progress notes that patient counseling has and will continue to take place outlining the risks and potential side effects of the medication.
Age Restrictions	For patients less than or equal to 64 years claim will automatically pay.
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

HRM - ANALGESICS

Products Affected

- ASCOMP-CODEINE
- *butalbital-apap-caff-cod*
- *butalbital-asa-caff-codeine*
- *indomethacin*
- *indomethacin er*
- *ketorolac tromethamine injection*
- *ketorolac tromethamine intramuscular*
- *ketorolac tromethamine oral*
- *meperidine hcl*
- *pentazocine-naloxone hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	Mild pain: codeine. Moderate to severe pain: short-term NSAIDs, tramadol, tramadol/APAP, morphine sulfate, hydrocodone/APAP, oxycodone, oxycodone/APAP, fentanyl.

HRM - ANTI-ARRHYTHMICS

Products Affected

- DIGITEK ORAL TABLET 250 MCG
- DIGOX ORAL TABLET 250 MCG
- *digoxin injection*
- *digoxin oral solution*
- *digoxin oral tablet 250 mcg*
- *disopyramide phosphate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

HRM - ANTIEMETIC DRUGS

Products Affected

- *promethazine hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

HRM - ANTIHISTAMINES

Products Affected

- *carbinoxamine maleate*
- *clemastine fumarate*
- *cyproheptadine hcl*
- *promethazine vc plain*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	cetirizine, fexofenadine, loratadine, desloratadine, levocetirizine

HRM - ANTIHYPERTENSIVE AGENTS

Products Affected

- *methyldopa*
- *methyldopa-hydrochlorothiazide*
- *methyldopate hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

HRM - ANTIPARKINSON AGENTS

Products Affected

- *benztropine mesylate*
- *trihexyphenidyl hcl*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	For the treatment of Parkinsonism, a trial of at least 1 formulary drug that is not an HRM in elderly (e.g., carbidopa/levodopa, pramipexole, ropinirole, bromocriptine, selegiline, rasagiline, entacapone, amantadine, etc.) or other type of clinical justification will be required in members 65 years of age and older. For the treatment of medication-induced movement disorder - extrapyramidal disease, a trial of at least 1 formulary drug that is not an HRM in elderly (e.g., amantadine, etc.) or other type of clinical justification will be required in members 65 years of age and older.

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HRM - CALCIUM CHANNEL BLOCKERS, DIHYDROPYRIDINE

Products Affected

- *nifedipine*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	extended-release nifedipine, nicardipine, amlodipine

HRM - ORAL AND TRANSDERMAL ESTROGENS AND PROGESTINS

Products Affected

- CLIMARA PRO
- *estradiol oral*
- *estropipate*
- MENEST
- PREMARIN INJECTION
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	Bone Density: alendronate, risedronate, ibandronate, raloxifene (zoledronic acid for bed-bound patients or for post-hip fracture). Vaginal Symptoms: vaginal estrogen cream

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

HRM - PLATELET INHIBITORS

Products Affected

- *dipyridamole*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	clopidogrel, aggrenox

HRM - SKELETAL MUSCLE RELAXANTS

Products Affected

- *carisoprodol*
- *carisoprodol-aspirin*
- *carisoprodol-aspirin-codeine*
- *chlorzoxazone*
- *cyclobenzaprine hcl*
- *methocarbamol*
- *orphenadrine citrate*
- *orphenadrine citrate er*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication.
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

HRM - SULFONYLUREAS

Products Affected

- *chlorpropamide*
- *glyburide*
- *glyburide micronized*
- *glyburide-metformin*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND the patient has tried at least one non-HRM alternative (listed in OTHER CRITERIA) AND the prescribing physician has been made aware that the requested drug is considered a high risk medication for elderly patients (age 65 years and older) and wishes to proceed with the originally prescribed medication .
Age Restrictions	PA applies to patients 65 years or older
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	glimepiride, glipizide

HRM-MEGESTROL

Products Affected

- *megestrol acetate oral suspension 625 mg/5ml*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	The drug is being prescribed for an FDA-approved indication AND If formulary non HRM alternatives for diagnosis of cachexia secondary to chronic illness (dronabinol, oxandrolone) considered safe and effective in the elderly are available, then the member had an inadequate response, intolerable side effect, or contraindication to at least 2 of the alternative(s) AND the prescribing physician attests to the medical necessity for using this high risk medication, AND anticipated treatment course/duration. For treatment of cancer related diagnosis or endometrial hyperplasia, or endometriosis, requests will be automatically approved.
Age Restrictions	Automatic approval if member is less than 65 years of age. Prior Auth required for age 65 or older.
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	Applies to New Starts only

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

HYDROXYPROGESTERONE CAPROATE

Products Affected

- *hydroxyprogesterone caproate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Breast, cervical, hepatocellular, uterine, or vaginal cancers, hepatic or thromboembolic disease, jaundice, or vaginal bleeding
Required Medical Information	Supporting statement of diagnosis from physician
Age Restrictions	16 years of age and older
Prescriber Restrictions	None
Coverage Duration	21 weeks
Other Criteria	None

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND One of the following: 1) Used in combination with Fulvestrant (fulvestrant) and disease has progressed following endocrine therapy OR 2) Used in combination with an aromatase inhibitor AND One of the following: 1) patient is a postmenopausal woman OR 2) both of the following: patient is a premenopausal or perimenopausal woman and patient is receiving a luteinizing hormone-releasing hormone (LHRH) agonist [e.g., Zoladex (goserelin)].
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

ICLUSIG

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic myelogenous leukemia (CML) AND One of the following: A) History of failure, resistance, relapse, contraindication, or intolerance to at least TWO other tyrosine kinase inhibitors (i.e., GLEEVEC [imatinib], SPRYCEL, TASIGNA, and BOSULIF), or B) Patient has the T315I mutation. OR Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND One of the following: A) History of failure, resistance relapse, contraindication, or intolerance to at least TWO other FDA-approved tyrosine kinase inhibitors (i.e., GLEEVEC [imatinib], SPRYCEL), or B) Patient has the T315I mutation.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsed or refractory acute myelogenous leukemia (AML) with isocitrate dehydrogenase 2 mutation expression, as detected by an FDA approved test
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	None

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of mantle cell lymphoma (MCL) in patients who have received at least one prior therapy OR chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) OR chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL) with 17p deletion OR Waldenstrom's macroglobulinemia (WM) OR marginal zone lymphoma (MZL) who require systemic therapy in patients who have received at least one prior anti-CD20-based therapy OR chronic graft-versus-host disease (cGVHD) after failure of one or more lines of systemic therapy.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

IMFINZI

Products Affected

- IMFINZI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of locally advanced or metastatic urothelial carcinoma. Patient must have progressed on or following platinum-containing chemotherapy, or within 12 months of neoadjuvant or adjuvant platinum containing chemotherapy OR Unresectable Stage III, non-small cell lung cancer without progression following concurrent platinum-based chemotherapy and radiation therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12/31/2018
Other Criteria	None

INTRAROSA

Products Affected

- INTRAROSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia.
Required Medical Information	Diagnosis of moderate to severe dyspareunia or atrophic vaginitis AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (e.g. Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Patient does not have renal or hepatic impairment.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 3 months, Reauthorization: 12 months
Other Criteria	None

INVANZ

Products Affected

- INVANZ

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Invanz (ertapenem sodium) is contraindicated in patients with a hypersensitivity to ertapenem or other drugs of the same class in patients with a prior anaphylactic reaction to beta-lactams and in patients with a hypersensitivity to amide-type anesthetics.
Required Medical Information	Labs with culture and sensitivity information.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

JEVTANA

Products Affected

- JEVTANA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Jevtana (cabazitaxel) therapy is contraindicated in patients with hypersensitivity to cabazitaxel polysorbate 80 or any component of the formulation neutrophil count = 1500/mm ³ .
Required Medical Information	This agent may be considered medically necessary when the following criteria are met: Hormone-Refractory Metastatic Prostate Cancer. The member must have a diagnosis of hormone-refractory metastatic prostate cancer. The member must have previously been treated with a docetaxol-containing treatment regimen. The member must be taking Jevtana in combination with prednisone. The member must BE MALE.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

JUXTAPID

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests. Pregnancy. Concomitant use with strong or moderate CYP3A4 inhibitors.
Required Medical Information	Diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (i.e., LDLRAP1 or ARH), or b) both of the following: 1) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. Patient has been receiving at least 12 consecutive weeks of ONE LDL-C lowering prescription therapy and will continue to receive an LDL-C lowering prescription therapy. History of failure after 12 consecutive weeks or intolerance to PCSK9 inhibitor therapy. One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: LDL-C greater than or equal to 100 mg/dL with ASCVD OR LDL-C greater than or equal to 130 mg/dL without ASCVD. Not used in combination with Kynamro (mipomersen). Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (i.e., Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (e.g., clarithromycin).
Age Restrictions	None

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

PA Criteria	Criteria Details
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis AND the patient has 1 mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

KEYTRUDA

Products Affected

- KEYTRUDA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	<p>Diagnosis of unresectable or metastatic melanoma OR first-line treatment of metastatic non-small cell lung cancer (NSCLC) in patients with high PD-L1 expressing tumors and with no EGFR or ALK genomic tumor aberrations OR treatment of metastatic NSCLC in patients with PD-L1 expression who have disease progression on or after platinum-containing chemotherapy (patients with EGFR or ALK genomic tumor aberrations should have disease progression on approved therapy for these aberrations prior to receiving Keytruda) OR recurrent or metastatic cervical cancer with tumor PD-L1 expression and disease progression on or after previous chemotherapy OR recurrent or metastatic squamous cell carcinoma of the head and neck in patients with disease progression on or after platinum-containing chemotherapy OR treatment of adult or pediatric patients with classical Hodgkin lymphoma (in patients who are refractory or who have relapsed after 3 or more prior lines of therapy) OR first-line treatment (in combination with pemetrexed plus carboplatin) of metastatic nonsquamous NSCLC OR locally advanced or metastatic urothelial carcinoma (in patients who are not eligible for cisplatin-containing chemotherapy, or who have had disease progression during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy) OR unresectable or metastatic solid tumors that have been identified as having a biomarker referred to as microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) (solid</p>

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
 2018 Prior Authorization Criteria

PA Criteria	Criteria Details
	tumors and colorectal cancer) OR treatment of recurrent locally advanced or metastatic gastric or gastroesophageal junction adenocarcinoma and tumors express PD-L1 (as determined by an FDA-approved test) with disease progression on or after 2 (or more) prior lines of therapy including fluoropyrimidine and platinum-containing chemotherapy (and if appropriate HER2/neu-targeted therapy)
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

Formulary ID: 18317
 Last Updated: 10/18/2018
 Version: 20 - Effective: 11/01/2018

KISQALI

Products Affected

- KISQALI 200 DOSE
- KISQALI 400 DOSE
- KISQALI 600 DOSE
- KISQALI FEMARA 200 DOSE
- KISQALI FEMARA 400 DOSE
- KISQALI FEMARA 600 DOSE

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of endocrine-based treatment of hormone receptor (HR)-positive, HER2-negative advanced or metastatic breast cancer in combination with an aromatase inhibitor in postmenopausal women
Age Restrictions	Age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or gastroenterologist
Coverage Duration	12/31/2018
Other Criteria	None

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy
Required Medical Information	Supporting statement of diagnosis and relevant medical information from physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

KYNAMRO

Products Affected

- KYNAMRO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Moderate to severe liver impairment or active liver disease including unexplained persistent abnormal liver function tests.
Required Medical Information	Diagnosis of homozygous familial hypercholesterolemia AND Patient has tried and had an inadequate response or intolerance to statins
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Initial - 6 months. Renewal - 12 months
Other Criteria	For renewal, patient has responded to therapy with a decrease in LDL levels.

LARTRUVO

Products Affected

- LARTRUVO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of soft tissue sarcoma (STS), histologic subtype for which an anthracycline-containing regimen is appropriate, previous treatment failure with radiotherapy or surgery and must document being used in combination with doxorubicin for the first 8 cycles.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 month
Other Criteria	None

LIDOCAINE

Products Affected

- *lidocaine external patch*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

MS INTERFERONS

Products Affected

- BETASERON

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of relapsing form of multiple sclerosis OR diagnosis of first clinical episode and MRI features consistent with multiple sclerosis.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

MYLOTARG

Products Affected

- MYLOTARG

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	INITIAL: A. Newly- diagnosed, CD33 positive acute myeloid leukemia (AML) or B. Relapsed or refractory CD33 positive AML. CONTINUATION OF THERAPY: 1) patient continues to meet initial criteria and 2) patients with newly diagnosed AML have not exceeded a maximum of 8 cycles
Age Restrictions	Relapsed or refractory AML: 2 years and older, Newly diagnosed AML: 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of early stage HER2-positive breast cancer. Must be used after trastuzumab-based therapy, as an adjuvant treatment.
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

NORTHERA

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Request will be approved for the following indication(s): orthostatic dizziness, light-headedness, or the feeling that you are about to black out in adults with neurogenic orthostatic hypotension (NOH) caused by primary autonomic failure (i.e., Parkinson disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, and non-diabetic autonomic neuropathy).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Patient diagnosis of pseudobulbar affect.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

NULOJIX

Products Affected

- NULOJIX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Kidney transplant: The medication is being used for prevention of kidney transplant organ rejection AND The patient is immune to the Epstein-Barr virus (i.e. EBV seropositive) AND The patient is prescribed concurrent therapy with mycophenolate and corticosteroids
Age Restrictions	Kidney transplant: 18 years of age or older
Prescriber Restrictions	Kidney transplant: Prescriber is experienced in immunosuppressive therapy and management of transplant patients
Coverage Duration	12/31/2018
Other Criteria	None

NUPLAZID

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Parkinson's disease psychosis including hallucinations and/or delusions
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Pregnancy.
Required Medical Information	Diagnosis of pulmonary arterial hypertension WHO group I AND diagnosis was confirmed by right heart catheterization AND female patients are enrolled in the OPSUMIT REMS program
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	6 months - initial. 12 months - renewal
Other Criteria	For renewal, medication was effective (i.e. improved 6 minute walk distance, oxygen saturation, etc.)

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Initial Therapy: Must have 1. Diagnosis of cystic fibrosis (CF) with documented homozygous F508del mutation confirmed by FDA-approved CF mutation test. Continuation of therapy: 1. Documentation patient is tolerating and responding to medication (i.e. improved FEV1, weight gain, decreased exacerbations, etc.)
Age Restrictions	Must be greater than or equal to 12 years of age
Prescriber Restrictions	Must be prescribed by, or in conjunction with, a pulmonologist or is from a CF center accredited by the Cystic Fibrosis Foundation
Coverage Duration	12/31/2018
Other Criteria	None

OSPHENA

Products Affected

- OSPHENA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Vaginal bleeding or dysfunctional uterine bleeding of an undetermined origin, known or suspected estrogen-dependent neoplasia, acute thromboembolism or a past history of thromboembolic disease (including patients with a history of DVT, pulmonary embolism, retinal vein thrombosis, stroke, or myocardial infarction, known or suspected pregnancy.
Required Medical Information	Diagnosis of moderate to severe dyspareunia or atrophic vaginitis AND A) Patient must be female, B) Patient must be menopausal or postmenopausal, C) Patient has tried and failed, has a contraindication or intolerance to a low dose vaginal estrogen preparation (e.g. Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem), D) Dose must not exceed 1 tablet per day, E) Patient does not have hepatic impairment.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 2 months, Reauthorization: 12 months
Other Criteria	None

PCSK9 INHIBITOR

Products Affected

- PRALUENT
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	For PRALUENT: MUST MEET CRITERIA #1 OR #3. For REPATHA: MUST MEET CRITERIA #1, #2, OR #3. 1. Diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by genotyping OR Simon Broome criteria: Total cholesterol greater than 290mg/dL or LDL cholesterol greater than 190mg/dL, PLUS ONE OF THE FOLLOWING: Tendon xanthomas in patient or 1st degree relative (parent, sibling, child) or 2nd degree relative (grandparent, uncle, aunt) OR DNA-based evidence of LDL receptor mutation, familial defective apo B-100, or PCSK9 mutation. 2a. Myocardial infarction prophylaxis, stroke prophylaxis, and to reduce risk of coronary revascularization in patients with established CVD OR 2b. Diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by genotyping OR diagnosis based on the following: a. History of untreated LDL-C greater than 500 mg/dL AND xanthoma before 10 years of age OR b. Documentation of HeFH in both parents. 3. Diagnosis of clinical atherosclerotic cardiovascular disease as defined as one of the following: a. acute coronary syndrome, b. history of myocardial infarction, c. stable/unstable angina, d. coronary or other arterial revascularization, e. stroke, f. transient ischemic stroke, g. peripheral arterial disease presumed to be atherosclerotic region AND MEETS CRITERIA #4, #5, and #6. 4. Provide baseline and current LDL-C. 5. LDL-C greater than or equal to 70mg/dL. 6. Used in combination with maximally tolerated high-

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

PA Criteria	Criteria Details
	intensity statin OR MEETS CRITERIA #7 AND #8. 7. Statin intolerant 8. LDL-C greater than or equal to 70mg/dL. CONTINUING THERAPY: 1. Documented response to Praluent or Repatha, defined as ONE of the following: a. The patient is tolerating medication b. Will continue to be used in combination with maximally tolerated statin (unless statin intolerant).
Age Restrictions	Repatha: 13 years of age or older for diagnosis HoFM, Diagnosis CVD or HeFH AND Praluent or Repatha : 18 years of age or older
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist
Coverage Duration	Initial approval: 8 weeks, Renewal approval: Plan Year
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

PROVIGIL

Products Affected

- *modafinil*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

RADICAVA

Products Affected

- RADICAVA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Known hypersensitivity to sulfite
Required Medical Information	Diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	age 18 years and older
Prescriber Restrictions	None
Coverage Duration	12 months
Other Criteria	None

REGRANEX

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diabetic Neuropathic Ulcers: Diabetic patient with ulcer wound. Treatment will be given in combination with ulcer wound care (e.g., debridement, infection control, and/or pressure relief).
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	Diabetic Neuropathic Ulcers: Maximum 5 months.
Other Criteria	None

REVATIO

Products Affected

- *sildenafil citrate*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of BRCA mutation-positive (germline and/or somatic) epithelial ovarian, fallopian tube, or primary peritoneal cancer in patients who have received 2 or more prior chemotherapy regimens OR Diagnosis of recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer after a complete or partial response to platinum-based chemotherapy
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 month
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Angioedema
Required Medical Information	Diagnosis of treatment naive FLT3 mutation-positive acute myelogenous leukemia (AML) and must be used in combination with standard cytarabine and daunorubicin induction and consolidation therapy or diagnosis of systemic mastocytosis.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12/31/2018
Other Criteria	None

SAMSCA

Products Affected

- SAMSCA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of cystic fibrosis and patient is homozygous for the F508del mutation OR have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor verified by an FDA-cleared CF mutation test
Age Restrictions	12 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial-6 months. Renewal-12 months.
Other Criteria	None

TOBI

Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	This agent may be considered medically necessary when the following criteria are met: Cystic Fibrosis. The patient has a diagnosis of cystic fibrosis (CF).The patient is colonized with P.aeruginosa
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

TRETINOIN

Products Affected

- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Approval will be given to all members using this agent for a medically necessary FDA approved non-cosmetic indication.
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Patients at increased risk of osteogenic sarcoma.
Required Medical Information	Diagnosis of osteoporosis in post-menopausal women at high risk for fracture. Member must have failed therapy with a bisphosphonate (defined by a fracture while on therapy or worsening bone density) unless such a trial is shown to be inappropriate or contraindicated (i.e., presence of severe osteoporosis [T-scores -3.0 or worse in lumbar spine, femoral neck, or total hip region], history of major osteoporotic fracture, presence of renal insufficiency, etc.) AND member has at least one of the following: T-score equal to or worse than -2.5 in the lumbar spine, femoral neck, or total hip region OR a FRAX calculator based 10-year risk of at least 20% for a major osteoporotic fracture (spine, shoulder, hip, or wrist), or a 10-year risk of at least 3% for a hip fracture OR presence or history of osteoporotic fracture.
Age Restrictions	18 years of age and older
Prescriber Restrictions	None
Coverage Duration	Initial: 12 months. Reauth: Treatment duration has not exceeded 24 months during patient lifetime.
Other Criteria	None

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

VENCLEXTA

Products Affected

- VENCLEXTA

- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of chronic lymphocytic leukemia (CLL) OR small lymphocytic lymphoma, with or without 17p deletion and patient has had at least 1 prior therapy
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	BREAST CANCER (1) Patient must have a diagnosis of advanced or metastatic breast cancer AND (2a) must be used in combination with fulvestrant for the treatment of disease progression following endocrine therapy OR (2b) used as monotherapy for treatment of disease progression following endocrine therapy and patient has already received at least one prior chemotherapy regimen of Ibrance or Kisqali OR (2c) used as initial endocrine-based treatment in combination with an aromatase inhibitor AND (3) disease is hormone receptor positive AND human epidermal growth factor 2 (HER2)- negative
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of therapy

VYXEOS

Products Affected

- VYXEOS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of therapy-related acute myelogenous leukemia (AML) OR acute myelogenous leukemia (AML) with myelodysplasia-related changes. If the patient has the diagnosis of therapy-related AML, it must be newly diagnosed.
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	None

XADAGO

Products Affected

- XADAGO

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	Concurrent use of MAOI therapy, including linezolid
Required Medical Information	Diagnosis of Parkinson's Disease AND will be used as an adjunctive treatment to levodopa/carbidopa
Age Restrictions	age 18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	12 months
Other Criteria	None

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Documented diagnosis of locally advanced or metastatic non-small cell lung cancer. Member has the anaplastic lymphoma receptor tyrosine kinase (ALK) genetic mutation as detected by an FDA-approved test.
Age Restrictions	None
Prescriber Restrictions	must be prescribed by an oncologist
Coverage Duration	12/31/2018
Other Criteria	None

XTANDI

Products Affected

- XTANDI

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Supporting statement of diagnosis from the physician
Age Restrictions	None
Prescriber Restrictions	None
Coverage Duration	12/31/2018
Other Criteria	None

XURIDEN

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of Hereditary orotic aciduria
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with a specialist that treats metabolic defects
Coverage Duration	12 months
Other Criteria	None

YONDELIS

Products Affected

- YONDELIS

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of unresectable or metastatic soft tissue sarcoma (liposarcoma or leiomyosarcoma) in patients who have received a prior anthracycline-containing regimen
Age Restrictions	18 years of age and older
Prescriber Restrictions	Must be prescribed by an oncologist
Coverage Duration	12/31/2018
Other Criteria	None

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of metastatic castration-resistant prostate cancer, and used in combination with methylprednisolone AND Documented history of trial with, inadequate treatment response, adverse event, or contraindication to Zytiga
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or urologist
Coverage Duration	12 months
Other Criteria	None

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Covered Uses	All medically accepted indications not otherwise excluded from Part D
Exclusion Criteria	None
Required Medical Information	Diagnosis of recurrent epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer and patient had a complete or partial response to platinum-based chemotherapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or gynecologist
Coverage Duration	12/31/2018
Other Criteria	None

PART B VERSUS PART D

Products Affected

- ABRAXANE INTRAVENOUS SUSPENSION RECONSTITUTED 100 MG
- *acetylcysteine inhalation solution 10 %, 20 %*
- *acyclovir sodium intravenous solution 50 mg/ml*
- ADRIAMYCIN INTRAVENOUS SOLUTION 2 MG/ML
- *albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, (5 mg/ml) 0.5%, 0.63 mg/3ml, 1.25 mg/3ml*
- ALDURAZYME INTRAVENOUS SOLUTION 2.9 MG/5ML
- ALIMTA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 500 MG
- AMBISOME INTRAVENOUS SUSPENSION RECONSTITUTED 50 MG
- AMINOSYN II INTRAVENOUS SOLUTION 10 %, 8.5 %
- AMINOSYN II/ELECTROLYTES INTRAVENOUS SOLUTION 8.5 %
- AMINOSYN/ELECTROLYTES INTRAVENOUS SOLUTION 7 %, 8.5 %
- AMINOSYN-HBC INTRAVENOUS SOLUTION 7 %
- AMINOSYN-PF INTRAVENOUS SOLUTION 10 %, 7 %
- AMINOSYN-RF INTRAVENOUS SOLUTION 5.2 %
- *amiodarone hcl intravenous solution 150 mg/3ml*
- *amphotericin b injection solution reconstituted 50 mg*
- *ampicillin-sulbactam sodium injection solution reconstituted 15 (10-5) gm, 3 (2-1) gm*
- ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG
- ARRANON INTRAVENOUS SOLUTION 5 MG/ML
- ASTAGRAF XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.5 MG, 1 MG, 5 MG
- ATGAM INTRAVENOUS INJECTABLE 50 MG/ML
- AVASTIN INTRAVENOUS SOLUTION 100 MG/4ML
- *azacitidine injection suspension reconstituted 100 mg*
- AZASAN ORAL TABLET 100 MG, 75 MG
- *azathioprine oral tablet 50 mg*
- *azathioprine sodium injection solution reconstituted 100 mg*
- BAVENCIO INTRAVENOUS SOLUTION 200 MG/10ML
- BELEODAQ INTRAVENOUS SOLUTION RECONSTITUTED 500 MG
- BENLYSTA INTRAVENOUS SOLUTION RECONSTITUTED 120 MG
- BICNU INTRAVENOUS SOLUTION RECONSTITUTED 100 MG
- BIVIGAM INTRAVENOUS SOLUTION 10 GM/100ML
- *bleomycin sulfate injection solution reconstituted 30 unit*
- *bortezomib intravenous solution reconstituted 3.5 mg*
- *budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml*
- *busulfan intravenous solution 6 mg/ml*
- *calcitonin (salmon) nasal solution 200 unit/act*
- *calcitriol intravenous solution 1 mcg/ml*

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

- *calcitriol oral capsule 0.25 mcg, 0.5 mcg*
- *calcitriol oral solution 1 mcg/ml*
- CAPASTAT SULFATE INJECTION SOLUTION RECONSTITUTED 1 GM
- *carboplatin intravenous solution 150 mg/15ml*
- *casprofungin acetate intravenous solution reconstituted 50 mg, 70 mg*
- CELLCEPT INTRAVENOUS INTRAVENOUS SOLUTION RECONSTITUTED 500 MG
- CEREZYME INTRAVENOUS SOLUTION RECONSTITUTED 400 UNIT
- *chlorpromazine hcl injection solution 50 mg/2ml*
- *chlorpromazine hcl oral tablet 10 mg, 25 mg*
- *chorionic gonadotropin intramuscular solution reconstituted 10000 unit*
- *cisplatin intravenous solution 50 mg/50ml*
- *cladribine intravenous solution 10 mg/10ml*
- CLINIMIX E/DEXTROSE (2.75/10) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX E/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX E/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (4.25/25) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX E/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
- CLINIMIX E/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
- CLINIMIX E/DEXTROSE (5/25) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (2.75/5) INTRAVENOUS SOLUTION 2.75 %
- CLINIMIX/DEXTROSE (4.25/10) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (4.25/20) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (4.25/25) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (4.25/5) INTRAVENOUS SOLUTION 4.25 %
- CLINIMIX/DEXTROSE (5/15) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (5/20) INTRAVENOUS SOLUTION 5 %
- CLINIMIX/DEXTROSE (5/25) INTRAVENOUS SOLUTION 5 %
- CLINISOL SF INTRAVENOUS SOLUTION 15 %
- *clofarabine intravenous solution 1 mg/ml*
- *colistimethate sodium (cba) injection solution reconstituted 150 mg*
- *cromolyn sodium inhalation nebulization solution 20 mg/2ml*
- *cyclophosphamide oral capsule 25 mg, 50 mg*
- *cyclosporine intravenous solution 50 mg/ml*
- *cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg*
- *cyclosporine modified oral solution 100 mg/ml*
- *cyclosporine oral capsule 100 mg, 25 mg*
- CYRAMZA INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML
- *cytarabine (pf) injection solution 100 mg/ml*
- *cytarabine injection solution 20 mg/ml*
- *dacarbazine intravenous solution reconstituted 200 mg*
- *dactinomycin intravenous solution reconstituted 0.5 mg*

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

- *daptomycin intravenous solution reconstituted 500 mg*
- *daunorubicin hcl intravenous injectable 5 mg/ml*
- *decitabine intravenous solution reconstituted 50 mg*
- DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML
- *dexrazoxane intravenous solution reconstituted 250 mg*
- *dextrose intravenous solution 10 %, 5 %*
- *diphtheria-tetanus toxoids dt intramuscular suspension 25-5 lfu/0.5ml*
- *docetaxel intravenous concentrate 80 mg/4ml*
- *docetaxel intravenous solution 160 mg/16ml*
- *doripenem intravenous solution reconstituted 500 mg*
- *doxercalciferol intravenous solution 4 mcg/2ml*
- *doxercalciferol oral capsule 0.5 mcg, 1 mcg, 2.5 mcg*
- *doxorubicin hcl intravenous solution 2 mg/ml*
- *doxorubicin hcl liposomal intravenous injectable 2 mg/ml*
- *dronabinol oral capsule 10 mg, 2.5 mg, 5 mg*
- ELAPRASE INTRAVENOUS SOLUTION 6 MG/3ML
- ELIGARD SUBCUTANEOUS KIT 22.5 MG, 30 MG, 45 MG, 7.5 MG
- ELITEK INTRAVENOUS SOLUTION RECONSTITUTED 1.5 MG, 7.5 MG
- EMEND ORAL SUSPENSION RECONSTITUTED 125 MG
- ENGERIX-B INJECTION SUSPENSION 10 MCG/0.5ML, 20 MCG/ML
- ENVARSUS XR ORAL TABLET EXTENDED RELEASE 24 HOUR 0.75 MG, 1 MG, 4 MG
- *epirubicin hcl intravenous solution 200 mg/100ml*
- ERBITUX INTRAVENOUS SOLUTION 100 MG/50ML
- ETOPOPHOS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG
- *etoposide intravenous solution 100 mg/5ml*
- FABRAZYME INTRAVENOUS SOLUTION RECONSTITUTED 35 MG, 5 MG
- FASLODEX INTRAMUSCULAR SOLUTION 250 MG/5ML
- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 120 MG, 80 MG
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 5 GM/50ML
- *fluconazole in sodium chloride intravenous solution 200-0.9 mg/100ml-%, 400-0.9 mg/200ml-%*
- *fludarabine phosphate intravenous solution reconstituted 50 mg*
- *fluorouracil intravenous solution 5 gm/100ml*
- FOLOTYN INTRAVENOUS SOLUTION 40 MG/2ML
- FREAMINE HBC INTRAVENOUS SOLUTION 6.9 %
- GAMASTAN S/D INTRAMUSCULAR INJECTABLE (10ML), (2ML)
- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA INTRAVENOUS SOLUTION RECONSTITUTED 10 GM, 5 GM
- GAMMAKED INJECTION SOLUTION 1 GM/10ML

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- *ganciclovir sodium intravenous solution reconstituted 500 mg*
- *gemcitabine hcl intravenous solution reconstituted 1 gm*
- GENGRAF ORAL CAPSULE 100 MG, 25 MG
- GENGRAF ORAL SOLUTION 100 MG/ML
- *granisetron hcl intravenous solution 0.1 mg/ml, 1 mg/ml*
- *granisetron hcl oral tablet 1 mg*
- HALAVEN INTRAVENOUS SOLUTION 1 MG/2ML
- *heparin (porcine) in d5w intravenous solution 40-5 unit/ml-%*
- *heparin sodium (porcine) injection solution 1000 unit/ml, 10000 unit/ml, 20000 unit/ml, 5000 unit/ml*
- HEPATAMINE INTRAVENOUS SOLUTION 8 %
- HERCEPTIN INTRAVENOUS SOLUTION RECONSTITUTED 150 MG, 440 MG
- *idarubicin hcl intravenous solution 10 mg/10ml*
- *ifosfamide intravenous solution reconstituted 1 gm*
- IMOVAX RABIES INTRAMUSCULAR INJECTABLE 2.5 UNIT/ML
- INTRON A INJECTION SOLUTION 10000000 UNIT/ML, 6000000 UNIT/ML
- INTRON A INJECTION SOLUTION RECONSTITUTED 10000000 UNIT, 18000000 UNIT, 50000000 UNIT
- *ipratropium bromide inhalation solution 0.02 %*
- *ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml*
- *irinotecan hcl intravenous solution 100 mg/5ml*
- ISTODAX (OVERFILL) INTRAVENOUS SOLUTION RECONSTITUTED 10 MG
- KEPIVANCE INTRAVENOUS SOLUTION RECONSTITUTED 6.25 MG
- KYPROLIS INTRAVENOUS SOLUTION RECONSTITUTED 30 MG, 60 MG
- *leucovorin calcium injection solution reconstituted 100 mg, 350 mg*
- *leuprolide acetate injection kit 1 mg/0.2ml*
- *levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml*
- *levocarnitine oral solution 1 gm/10ml*
- *levocarnitine oral tablet 330 mg*
- *levoleucovorin calcium intravenous solution 175 mg/17.5ml*
- *levoleucovorin calcium intravenous solution reconstituted 50 mg*
- *lincomycin hcl injection solution 300 mg/ml*
- *melphalan hcl intravenous solution reconstituted 50 mg*
- *mesna intravenous solution 100 mg/ml*
- *methotrexate oral tablet 2.5 mg*
- *methotrexate sodium (pf) injection solution 250 mg/10ml, 50 mg/2ml*
- *methotrexate sodium injection solution 250 mg/10ml*
- *methotrexate sodium injection solution reconstituted 1 gm*
- *methylprednisolone sodium succ injection solution reconstituted 1000 mg*
- *metoprolol tartrate intravenous solution 5 mg/5ml*

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

- *metoprolol tartrate intravenous solution cartridge 5 mg/5ml*
- *metronidazole in nacl intravenous solution 500-0.79 mg/100ml-%*
- MIACALCIN INJECTION SOLUTION 200 UNIT/ML
- MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML
- *mitomycin intravenous solution reconstituted 20 mg, 40 mg, 5 mg*
- *mitoxantrone hcl intravenous concentrate 25 mg/12.5ml*
- MUSTARGEN INJECTION SOLUTION RECONSTITUTED 10 MG
- *mycophenolate mofetil hcl intravenous solution reconstituted 500 mg*
- *mycophenolate mofetil oral capsule 250 mg*
- *mycophenolate mofetil oral suspension reconstituted 200 mg/ml*
- *mycophenolate mofetil oral tablet 500 mg*
- *mycophenolate sodium oral tablet delayed release 180 mg, 360 mg*
- NAGLAZYME INTRAVENOUS SOLUTION 1 MG/ML
- NEBUPENT INHALATION SOLUTION RECONSTITUTED 300 MG
- NEPHRAMINE INTRAVENOUS SOLUTION 5.4 %
- NIPENT INTRAVENOUS SOLUTION RECONSTITUTED 10 MG
- *nutrilipid intravenous emulsion 20 %*
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML
- *ondansetron hcl injection solution 4 mg/2ml, 4 mg/2ml (2ml syringe)*
- *ondansetron hcl oral solution 4 mg/5ml*
- *ondansetron hcl oral tablet 24 mg, 4 mg, 8 mg*
- *ondansetron oral tablet dispersible 4 mg, 8 mg*
- *oxaliplatin intravenous solution 100 mg/20ml*
- *oxaliplatin intravenous solution reconstituted 100 mg*
- *paclitaxel intravenous concentrate 100 mg/16.7ml*
- *pamidronate disodium intravenous solution 30 mg/10ml, 6 mg/ml, 90 mg/10ml*
- *paricalcitol intravenous solution 2 mcg/ml, 5 mcg/ml*
- *paricalcitol oral capsule 1 mcg, 2 mcg, 4 mcg*
- PERJETA INTRAVENOUS SOLUTION 420 MG/14ML
- *piperacillin sod-tazobactam so intravenous solution reconstituted 2.25 (2-0.25) gm*
- PLASMA-LYTE 148 INTRAVENOUS SOLUTION
- PLASMA-LYTE A INTRAVENOUS SOLUTION
- PLENAMINE INTRAVENOUS SOLUTION 15 %
- PREMASOL INTRAVENOUS SOLUTION 10 %, 6 %
- PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML
- PROCALAMINE INTRAVENOUS SOLUTION 3 %
- *prochlorperazine maleate oral tablet 10 mg, 5 mg*
- PROGRAF INTRAVENOUS SOLUTION 5 MG/ML
- PROLEUKIN INTRAVENOUS SOLUTION RECONSTITUTED 22000000 UNIT
- PROSOL INTRAVENOUS SOLUTION 20 %
- PULMOZYME INHALATION SOLUTION 1 MG/ML

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

- RABAVERT INTRAMUSCULAR SUSPENSION RECONSTITUTED
- RAPAMUNE ORAL SOLUTION 1 MG/ML
- RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 10 MCG/ML (1ML SYRINGE), 40 MCG/ML, 5 MCG/0.5ML
- RITUXAN INTRAVENOUS SOLUTION 100 MG/10ML, 500 MG/50ML
- SANDIMMUNE ORAL SOLUTION 100 MG/ML
- SENSIPAR ORAL TABLET 30 MG, 60 MG, 90 MG
- SIMULECT INTRAVENOUS SOLUTION RECONSTITUTED 20 MG
- *sirolimus oral tablet 0.5 mg, 1 mg, 2 mg*
- SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML
- SYNDROS ORAL SOLUTION 5 MG/ML
- SYNERCID INTRAVENOUS SOLUTION RECONSTITUTED 150-350 MG
- *tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg*
- TECENTRIQ INTRAVENOUS SOLUTION 1200 MG/20ML
- TEFLARO INTRAVENOUS SOLUTION RECONSTITUTED 400 MG, 600 MG
- *tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml*
- *thiotepa injection solution reconstituted 15 mg*
- THYMOGLOBULIN INTRAVENOUS SOLUTION RECONSTITUTED 25 MG
- *tigecycline intravenous solution reconstituted 50 mg*
- *tobramycin inhalation nebulization solution 300 mg/5ml*
- *topotecan hcl intravenous solution reconstituted 4 mg*
- TORISEL INTRAVENOUS SOLUTION 25 MG/ML
- *tranexamic acid intravenous solution 1000 mg/10ml*
- TRAVASOL INTRAVENOUS SOLUTION 10 %
- TREANDA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG, 25 MG
- TRELSTAR MIXJECT INTRAMUSCULAR SUSPENSION RECONSTITUTED 11.25 MG, 22.5 MG, 3.75 MG
- TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG
- TRISENOX INTRAVENOUS SOLUTION 12 MG/6ML
- TROPHAMINE INTRAVENOUS SOLUTION 10 %
- TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML
- VARUBI ORAL TABLET 90 MG
- VECTIBIX INTRAVENOUS SOLUTION 100 MG/5ML
- VELCADE INJECTION SOLUTION RECONSTITUTED 3.5 MG
- VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML
- *vinblastine sulfate intravenous solution 1 mg/ml*
- *vincristine sulfate intravenous solution 1 mg/ml*
- *vinorelbine tartrate intravenous solution 50 mg/5ml*
- XATMEP ORAL SOLUTION 2.5 MG/ML
- YERVOY INTRAVENOUS SOLUTION 50 MG/10ML
- ZALTRAP INTRAVENOUS SOLUTION 100 MG/4ML
- ZANOSAR INTRAVENOUS SOLUTION RECONSTITUTED 1 GM
- *zoledronic acid intravenous concentrate 4 mg/5ml*
- *zoledronic acid intravenous solution 5 mg/100ml*

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

- ZOMETA INTRAVENOUS SOLUTION 4 MG/100ML
- ZORTRESS ORAL TABLET 0.25 MG, 0.5 MG, 0.75 MG

Details

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

Alphabetical Listing

A

ABRAXANE	104
acetylcysteine.....	104
acyclovir sodium	104
ADCIRCA	2
ADEMPAS.....	3
ADRIAMYCIN	104
albuterol sulfate.....	104
ALDURAZYME	104
ALIMTA.....	104
ALIQOPA.....	4
ALUNBRIG.....	5
AMBISOME.....	104
AMINOSYN II.....	104
AMINOSYN II/ELECTROLYTES ..	104
AMINOSYN/ELECTROLYTES.....	104
AMINOSYN-HBC.....	104
AMINOSYN-PF	104
AMINOSYN-RF	104
amiodarone hcl	104
amphotericin b	104
ampicillin-sulbactam sodium ...	104
AMPYRA.....	6
aprepitant	19
ARANESP (ALBUMIN FREE)	7
ARCALYST.....	104
ARRANON	104
ASCOMP-CODEINE	39
ASTAGRAF XL.....	104
ATGAM	104
AUBAGIO	9
AURYXIA.....	10
AVASTIN.....	104
azacitidine.....	104
AZASAN.....	104
azathioprine	104
azathioprine sodium	104

B

BAVENCIO	104
bcg vaccine	11

BELEODAQ	104
BENLYSTA	104
benztropine mesylate.....	44
BETASERON.....	70
bexarotene	12
BICNU.....	104
BIVIGAM	104
bleomycin sulfate	104
bortezomib	104
BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG.....	13
BRIVIACT	14
budesonide	104
busulfan	104
butalbital-apap-caff-cod	39
butalbital-asa-caff-codeine.....	39

C

calcitonin (salmon)	104
calcitriol	104, 105
CALQUENCE.....	15
CAPASTAT SULFATE.....	105
CAPRELSA	16
carbinoxamine maleate	42
carboplatin	105
CARIMUNE NF	17
carisoprodol.....	48
carisoprodol-aspirin	48
carisoprodol-aspirin-codeine.....	48
casprofungin acetate	105
CELLCEPT INTRAVENOUS.....	105
CEREZYME.....	105
chlorpromazine hcl.....	105
chlorpropamide	49
chlorzoxazone	48
chorionic gonadotropin	105
cisplatin	105
cladribine	105
clemastine fumarate	42
CLIMARA PRO	46

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

CLINIMIX E/DEXTROSE (2.75/10)	105	DIGITEK ORAL TABLET 250 MCG	40
CLINIMIX E/DEXTROSE (2.75/5)	105	DIGOX ORAL TABLET 250 MCG ..	40
CLINIMIX E/DEXTROSE (4.25/10)	105	digoxin injection	40
CLINIMIX E/DEXTROSE (4.25/25)	105	digoxin oral solution.....	40
CLINIMIX E/DEXTROSE (4.25/5)	105	digoxin oral tablet 250 mcg.....	40
CLINIMIX E/DEXTROSE (5/15) .	105	diphtheria-tetanus toxoids dt ..	106
CLINIMIX E/DEXTROSE (5/20) .	105	dipyridamole.....	47
CLINIMIX E/DEXTROSE (5/25) .	105	disopyramide phosphate.....	40
CLINIMIX/DEXTROSE (2.75/5) .	105	docetaxel	106
CLINIMIX/DEXTROSE (4.25/10)	105	doripenem.....	106
CLINIMIX/DEXTROSE (4.25/20)	105	doxercalciferol.....	106
CLINIMIX/DEXTROSE (4.25/25)	105	doxorubicin hcl.....	106
CLINIMIX/DEXTROSE (4.25/5) .	105	doxorubicin hcl liposomal.....	106
CLINIMIX/DEXTROSE (5/15)....	105	dronabinol	106
CLINIMIX/DEXTROSE (5/20)....	105	E	
CLINIMIX/DEXTROSE (5/25)....	105	ELAPRASE	106
CLINISOL SF	105	ELIGARD	106
clofarabine	105	ELITEK.....	106
colistimethate sodium (cba)....	105	EMEND.....	106
cromolyn sodium	105	EMEND INTRAVENOUS	19
cyclobenzaprine hcl	48	EMPLICITI	20
cyclophosphamide.....	105	ENDARI.....	21
cyclosporine	105	ENGERIX-B	106
cyclosporine modified	105	ENTRESTO.....	22
cyproheptadine hcl	42	ENVARUSUS XR.....	106
CYRAMZA.....	105	EPCLUSA	36
cytarabine.....	105	epirubicin hcl	106
cytarabine (pf).....	105	ERBITUX	106
D		ERLEADA.....	23
dacarbazine.....	105	ERWINAZE.....	24
dactinomycin	105	ESBRIET.....	25
daptomycin	106	estradiol oral.....	46
daunorubicin hcl	106	estropipate	46
decitabine	106	ETOPOPHOS	106
DEPO-PROVERA	106	etoposide	106
dexrazoxane.....	106	F	
dextrose	106	FABRAZYME.....	106
		FARYDAK.....	28
		FASLODEX.....	106
		FENTORA BUCCAL TABLET 100	
		MCG, 200 MCG, 400 MCG, 600	
		MCG, 800 MCG	29

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

FIRMAGON	106	IMBRUVICA	55
FLEBOGAMMA DIF	106	IMFINZI	56
FLECTOR.....	30	IMOVAX RABIES	107
fluconazole in sodium chloride..	106	indomethacin	39
fludarabine phosphate	106	indomethacin er	39
fluorouracil.....	106	INTRAROSA	57
FOLOTYN	106	INTRON A.....	107
FREAMINE HBC	106	INVANZ.....	58
G		ipratropium bromide	107
GAMASTAN S/D	106	ipratropium-albuterol	107
GAMMAGARD.....	106	irinotecan hcl	107
GAMMAGARD S/D LESS IGA	106	ISTODAX (OVERFILL).....	107
GAMMAKED.....	106	J	
GAMMAPLEX.....	107	JEVTANA	59
GAMUNEX-C	107	JUXTAPID	60
ganciclovir sodium.....	107	K	
gemcitabine hcl	107	KALYDECO.....	62
GENGRAF.....	107	KEPIVANCE.....	107
GILENYA.....	31	ketorolac tromethamine injection	39
GILOTRIF	32	ketorolac tromethamine	
glyburide	49	intramuscular.....	39
glyburide micronized	49	ketorolac tromethamine oral	39
glyburide-metformin.....	49	KEYTRUDA.....	63
GOCOVRI.....	33	KISQALI 200 DOSE	65
granisetron hcl	107	KISQALI 400 DOSE	65
guanfacine hcl er	38	KISQALI 600 DOSE	65
H		KISQALI FEMARA 200 DOSE.....	65
HALAVEN	107	KISQALI FEMARA 400 DOSE.....	65
HARVONI	36	KISQALI FEMARA 600 DOSE.....	65
heparin (porcine) in d5w	107	KORLYM	66
heparin sodium (porcine)	107	KYNAMRO.....	67
HEPATAMINE	107	KYPROLIS.....	107
HERCEPTIN	107	L	
HETLIOZ.....	37	LARTRUVO.....	68
HP ACTHAR.....	1	LAZANDA	29
hydroxyprogesterone caproate...	51	leucovorin calcium	107
I		leuprolide acetate	107
IBRANCE.....	52	levaltbuterol hcl.....	107
ICLUSIG	53	levocarnitine	107
idarubicin hcl.....	107	levoleucovorin calcium	107
IDHIFA	54	lidocaine external patch.....	69
ifosfamide	107	lincomycin hcl	107

Formulary ID: 18317

Last Updated: 10/18/2018

Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

M

MAVYRET36
 megestrol acetate oral suspension
 625 mg/5ml50
 melphalan hcl 107
 MENEST46
 meperidine hcl.....39
 mesna 107
 methocarbamol.....48
 methotrexate 107
 methotrexate sodium..... 107
 methotrexate sodium (pf) 107
 methyldopa43
 methyldopa-hydrochlorothiazide.43
 methyldopate hcl43
 methylphenidate hcl38
 methylphenidate hcl er38
 methylphenidate hcl er (cd).....38
 methylprednisolone sodium succ
 107
 metoprolol tartrate 107, 108
 metronidazole in nacl..... 108
 MIACALCIN 108
 MIRCERA 108
 mitomycin..... 108
 mitoxantrone hcl..... 108
 modafinil82
 MUSTARGEN..... 108
 mycophenolate mofetil..... 108
 mycophenolate mofetil hcl..... 108
 mycophenolate sodium 108
 MYLOTARG 71

N

NAGLAZYME 108
 NEBUPENT 108
 NEPHRAMINE..... 108
 NERLYNX72
 nifedipine.....45
 NIPENT 108
 NORDITROPIN FLEXPRO.....34
 NORTHERA.....73
 NUEDEXTA 74

NULOJIX..... 75
 NUPLAZID 76
 nutrilipid 108

O

OCTAGAM..... 108
 ondansetron 108
 ondansetron hcl 108
 OPSUMIT..... 77
 ORKAMBI 78
 orphenadrine citrate..... 48
 orphenadrine citrate er..... 48
 OSPHENA 79
 oxaliplatin 108

P

paclitaxel..... 108
 pamidronate disodium..... 108
 paricalcitol..... 108
 pentazocine-naloxone hcl..... 39
 PERJETA..... 108
 piperacillin sod-tazobactam so. 108
 PLASMA-LYTE 148 108
 PLASMA-LYTE A..... 108
 PLENAMINE 108
 PRALUENT 80
 PREMARIN INJECTION 46
 PREMARIN ORAL..... 46
 PREMASOL..... 108
 PREMPHASE..... 46
 PREMPRO 46
 PRIVIGEN 108
 PROCALAMINE 108
 prochlorperazine maleate..... 108
 PROCRT INJECTION SOLUTION
 10000 UNIT/ML, 2000 UNIT/ML,
 20000 UNIT/ML, 3000 UNIT/ML,
 4000 UNIT/ML, 40000 UNIT/ML
 26
 PROGRAF 108
 PROLEUKIN 108
 promethazine hcl..... 41
 promethazine vc plain 42
 PROSOL 108

Formulary ID: 18317
 Last Updated: 10/18/2018
 Version: 20 - Effective: 11/01/2018

HealthSun 001 - SunPlus Advantage Plan
2018 Prior Authorization Criteria

PULMOZYME	108	TRELSTAR MIXJECT	109
R		tretinoin external cream	92
RABAVERT	109	tretinoin external gel 0.01 %, 0.025 %	92
RADICAVA	83	TREXALL	109
RAPAMUNE.....	109	trihexyphenidyl hcl	44
RECOMBIVAX HB.....	109	TRISENOX	109
REGRANEX.....	84	TROPHAMINE	109
REPATHA	80	TYMLOS	93
REPATHA PUSHTRONEX SYSTEM	80	TYSABRI	109
REPATHA SURECLICK	80	V	
RITUXAN.....	109	VARUBI.....	109
RUBRACA.....	86	VECTIBIX	109
RYDAPT	87	VELCADE.....	109
S		VENCLEXTA	94
SAMSCA	88	VENCLEXTA STARTING PACK.....	94
SANDIMMUNE.....	109	VENTAVIS	109
SENSIPAR	109	VERZENIO	95
sildenafil citrate	85	vinblastine sulfate.....	109
SIMULECT	109	vincristine sulfate	109
sirolimus.....	109	vinorelbine tartrate	109
STIVARGA.....	89	VYXEOS	96
SYMDEKO	90	X	
SYNAGIS	109	XADAGO.....	97
SYNDROS	109	XALKORI	98
SYNERCID.....	109	XATMEP	109
T		XTANDI.....	99
tacrolimus.....	109	XURIDEN.....	100
TECENTRIQ.....	109	Y	
TEFLARO.....	109	YERVOY	109
tetanus-diphtheria toxoids td ...	109	YONDELIS	101
thiotepa.....	109	YONSA.....	102
THYMOGLOBULIN.....	109	Z	
tigecycline.....	109	ZALTRAP	109
TOBI PODHALER	91	ZANOSAR.....	109
tobramycin.....	109	ZEJULA	103
topotecan hcl.....	109	ZEPATIER.....	36
TORISEL	109	zoledronic acid	109
tranexamic acid	109	ZOMETA	110
TRAVASOL	109	ZORTRESS.....	110
TREANDA.....	109		

Formulary ID: 18317
Last Updated: 10/18/2018
Version: 20 - Effective: 11/01/2018