people powered health plans

Prior Authorization Criteria Updates Effective January 1, 2022

UCare Individual & Family Plans
UCare Individual & Family Plans with M Health Fairview

On January 1, 2022, prior authorization criteria for the drugs listed below will be updated. These changes will be reflected in the 2022 Prior Authorization Criteria document.

Acthar	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Infantile Spasms - Younger than 2 years of age
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	Infantile Spasms - 1 month
Other Criteria	Infantile spasms - Approve. Other indications are not recommended for approval.

Bexarotene	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, other therapies tried
Age Restrictions	2 months and older up to 25 years of age (initial)
Prescriber Restrictions	prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	3 years

Other Criteria	Cutaneous T-Cell Lymphoma - Approve if pt has cutaneous manifestations and generic bexarotene is being requested. Brand name Tagretin will only be approved if the pt has tried the generic equivalent and the patient cannot tolerate the generic due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] which would result in a significant allergy or a serious adverse reaction, as per the prescriber [documentation required].

Cimzia	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications. Spondyloarthritis (SpA), Other subtypes.
Exclusion Criteria	Concurrent Use with a Biologic or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD).
Required Medical Information	diagnosis, medication history
Age Restrictions	CD/PP - 18 years and older
Prescriber Restrictions	AS/nr-axSpA/RA/SpA - prescribed by or in consultation with a rheumatologist. CD - prescribed by or in consultation with a gastroenterologist. PP - prescribed by or in consultation with a dermatologist. PsA - prescribed by or in consultation with a rheumatologist or a dermatologist.
Coverage Duration	Initial - 3 months. Continuation - 1 year.
Other Criteria	Ankylosing Spondylitis (AS) - approve if pt has tried TWO of Enbrel, Humira, and Taltz. Crohn's disease (CD) - approve if pt has tried Humira. Non-Radiographic Axial Spondyloarthritis (nr-axSpA) - approve if pt has C-reactive protein (CRP) elevated beyond the upper limit of normal OR sacroiliitis reported on magnetic resonance imaging (MRI). Plaque Psoriasis (PP) - approve if pt has tried two of Enbrel, Humira, Otezla, Skyrizi, Stelara subcutaneous, Taltz, and Tremfya. Psoriatic Arthritis (PsA) - approve if pt has tried two of Enbrel, Humira, Otezla, Stelara subcutaneous, Taltz, Tremfya, and Xeljanz/XR. Rheumatoid Arthritis (RA) - approve if pt has tried two of Actemra subcutaneous, Enbrel, Humira, Rinvoq, and Xeljanz/XR. Spondyloarthritis (SpA) - approve if pt has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet and has tried at least one conventional synthetic disease-modifying antirheumatic drug (DMARD). Continuation (RA, AS, PsA, PP) - approve if pt meets intial therapy requirements and has responded to therapy. Continuation (CD) - approve if pt meets initial therapy requirements, has responded to therapy and has been taking Cimzia for at least 90

	days.

Cometriq	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Non-Small Cell Lung Cancer. Dfferentiated Thyroid Carcinoma.
Exclusion Criteria	Metastatic Castration-Resistant Prostate Cancer
Required Medical Information	Diagnosis, mutation results
Age Restrictions	Differentiated Thyroid Carcinoma - 12 years or older. Medullary Thyroid Carinoma/NSCLC - 18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Medullary Thyroid Cancer - approve. Differentiated Thyroid Carcinoma (i.e., papillary, follicular, and Hürthle)- approve if refractory to radioactive iodine therapy. Non-Small Cell Lung Cancer - approve if pt has RET gene rearrangements.

Corlanor	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Plus Inappropriate Sinus Tachycardia.
Exclusion Criteria	Stable Angina Pectoris, in patients without CHF
Required Medical Information	Previous use of a Beta-blocker, LVEF, sinus rhythm, and resting HR
Age Restrictions	Heart Failure - 18 years or older, Heart Failure due to Dilated Cardiomyopathy in Peds - 17 years or younger
Prescriber Restrictions	prescribed by or in consultation with a cardiologist
Coverage Duration	1 year
Other Criteria	Heart Failure - Approve if pt has a LVEF equal to or less than 35% currently or prior to initiation of Corlanor therapy, pt is in normal sinus rhythm or sinus tachycardia with a resting heart rate of greater than 70 beats per minute, and pt has tried or is taking one beta

	blocker for heart failure or has a contraindication to its use. Heart Failure due to Dilated Cardiomyopathy in Pediatric Patients - Approve. Inappropriate Sinus Tachycardia - Approve.

Enbrel	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded plus Behcet's Disease, Graft-Versus-Host Disease, Pyoderma Gangrenosum, Spondylarthritis, and Still's Disease.
Exclusion Criteria	Concurrent Use with a Biologic DMARD or Targeted Synthetic DMARD. Crohn's disease. Inflammatory myopathies (polymyositis, dermatomyositis, inclusion body myositis). Hidradenitis Suppurativa. Polymyalgia Rheumatica. Large Vessel Vasculitis (Giant Cell Arteritis, Takayasu's Arteritis). Wegener's Granulomatosis.
Required Medical Information	Diagnosis and previous therapies tried
Age Restrictions	PP - 4 years or older
Prescriber Restrictions	Prescribed by or in consultation with: RA/AS/JIA/JRA/SpA/SD - rheumatologist. PP/PG - dermatologist. PsA - rheumatologist or dermatologist. Behcet's - rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist. GVHD - oncologist, hematologist, or a physician in a transplant center.
Coverage Duration	RA/AS/JIA/PP/PsA/BD/SpA/SD -3mo GVHD-1mo PG-4mo. Cont:RA/AS/JIA/PP/PsA-3y GVHD-4m others-1yr
Other Criteria	Rheumatoid Arthritis (RA) - Pt has tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) or biologic DMARD for at least 3 months. Ankylosing Spondylitis (AS) - Approve. Juvenile Idopathic Arthritis (JIA)/Juvenile Rheumatoid Arthritis (JRA) - Pt has tried one other agent for this condition or a biologic DMARD OR pt will be starting on Enbrel concurrently with methotrexate (MTX), sulfasalazine, or leflunomide OR pt has an absolute contraindication to MTX, sulfasalazine, or leflunomide OR pt has aggressive disease, as determined by the prescribing physician. Plaque Psoriasis (PP) - Approve if pt has tried at least one traditional systemic agent for psoriasis (e.g., MTX, cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light [PUVA]) or a biologic DMARD for at least 3 months, unless intolerant. Psoriatic Arthritis (PsA) - Approve. Behcet's - Approve if pt has tried at least one conventional therapy or adalimumab or infliximab. Graft vs. Host Disease (GVHD) - Approve if pt has tried one conventional treatment or is currently receiving one of these medications. Pyoderma Gangrenosum (PG) - Approve if pt

	has tried one systemic corticosteroid OR one other immunosuppressant for at least 2 months or was intolerant. Spondyloarthritis (SpA) - Approve if pt has arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet AND has tried at least ONE conventional synthetic DMARD OR The patient has axial spondyloarthritis with objective measures of inflammation (elevated CRD, sacroiliitis on MRI). Still's Disease - Approve if pt has tried one corticosteroid AND one conventional synthetic DMARD for at least 2 months or was intolerant. Continuation therapy - Approve if the pt has had a response as determined by the prescriber.

Hetlioz	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indication not otherwise excluded
Exclusion Criteria	
Required Medical Information	Diagnosis, other therapies tried.
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a physician who specializes in the treatment of sleep disorders.
Coverage Duration	Initial - 6 Months. Continuation - 1 Year
Other Criteria	Non-24-Hour Sleep Wake Disorder (Non-24) (Initial Therapy) - Pt is totally blind with no perception of light, AND Diagnosis of Non-24 is confirmed by meeting ONE of the following conditions (a or b): a) Assessment of at least one physiologic circadian phase marker, Note: Examples of physiologic circadian phase markers include measurement of urinary melatonin levels, dim light melatonin onset (as measured in blood or saliva), and assessment of core body temperature. OR b) If assessment of at least one physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for greater than or equal to 1 week plus evaluation of sleep logs recorded for greater than or equal to 1 month, AND Patient meets BOTH of the conditions: Patient has received at least 6 months of continuous therapy (i.e., 6 consecutive months of daily treatment) with melatonin under the guidance of a physician who specializes in the treatment sleep disorders AND Patient had inadequate efficacy with melatonin therapy according to the prescriber, Note: Examples of efficacy with melatonin therapy include entrainment, clinically meaningful or significant increases in nighttime sleep, and clinically meaningful or significant decreases in daytime sleep. Non-24-Hour Sleep Wake Disorder (Non-24)

	(Continuation of Therapy): Patient is totally blind with no perception of light, AND Patient meets both of the conditions: Patient has received at least 6 months of continuous therapy (i.e., 6 consecutive months of daily treatment) with melatonin under the guidance of a physician who specializes in the treatment sleep disorders, AND Patient had inadequate efficacy with melatonin therapy according to the prescriber Note: Examples of efficacy with melatonin therapy include entrainment, clinically meaningful or significant increases in nighttime sleep, and clinically meaningful or significant decreases in daytime sleep. AND Patient meets both of the conditions (a and b): a) Patient has received at least 6 months of continuous therapy (i.e., 6 consecutive months of daily treatment) with Hetlioz under the guidance of a physician who specializes in the treatment of sleep disorders Note: Patients who have not received at least 6 months of continuous Hetlioz therapy, or if the therapy has not been continuous (i.e., 6 consecutive months of daily treatment), should follow criteria 1 (initial therapy). And b) Patient has achieved adequate results with Hetlioz therapy according to the prescriber. Note: Examples of adequate results with Hetlioz therapy include entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep.

Kynmobi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indication not otherwise excluded
Exclusion Criteria	Concurrent Use with a Serotonin 5-HT3 Antagonist
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	1 year
Other Criteria	Parkinson's Disease - Approve if the pt is diagnosed with advanced Parkinsons disease, is experiencing "off" episodes (such as muscle stiffness, slow movements or difficulty starting movements), is currently receiving carbidopa/levodopa, and has previously tried one other treatment for off episodes to which the pt had significant intolerance to or inadequate efficacy from, according to the prescriber.

Nerlynx

PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, HER2 status, other therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	BCx Adjuvant - 1 year. BCx Advanced or Metastatic - 3 years.
Other Criteria	Breast Cancer, Adjuvant Therapy - Approve if pt has HER2 positive breast cancer, will not be using this medication in combination with HER2 antagonists, and the medication is requested for extended adjuvant therapy after the patient has completed 1 year of adjuvant therapy with trastuzumab intravenous products unless pt has tried adjuvant therapy with trastuzumab intravenous products and could not tolerate 1 year of therapy, according to the prescriber. Breast Cancer, Advanced or Metastatic - Approve if pt has HER2 positive breast cancer, the medication will be used in combination with capecitabine, and pt has tried at least two prior anti-HER2 based regimens in the metastatic setting.

Nuplazid	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	1 year
Other Criteria	Parkinsons Disease Psychosis - Approve if pt has hallucinations and delusions associated with Parkinsons disease psychosis and pt does not have dementia-related psychosis unrelated to the hallucinations

	and delusions associated with Parkinson's disease psychosis.

Odomzo	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, previous treatments
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 Years
Other Criteria	Basal Cell Carcinoma, Locally Advanced - Approve if pt has recurrent basal cell carcinoma following surgery or radiation therapy OR Patient is not a candidate for surgery and according to the prescriber, the patient is not a candidate for radiation therapy. Continuation - Approve.

Penicillamine	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, other therapies tried.
Age Restrictions	
Prescriber Restrictions	Wilson's disease - Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
Coverage Duration	3 years
Other Criteria	Wilson's Disease - Approve if pt has Wilson's Disease confirmed by genetic testing results confirming biallelic pathogenic ATP7B mutations or prescence of at least two of the following: Presence of Kayser-Fleischer rings, serum ceruloplasmin level less than 20 mg/dL, liver biopsy findings consistent with Wilson’s disease, or 24-hour

	urinary copper greater than 40 mcg/24 hours. Pt must also have tried Galzin, another zinc product, already been started on a penacillamine product, or the pt has symptoms of Wilson's disease and zinc would not be an appropriate therapy. Cystinuria - Approve if, according to the prescriber, patient has tried increased fluid intake, restriction of sodium and protein, and urinary alkalinization.

Targretin (Topical)	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	3 years
Other Criteria	Cutaneous T-Cell Lymphoma - Approve if pt has cutaneous manifestations.

Topical Testosterone	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment (i.e., Endocrinologic Masculinization).
Exclusion Criteria	Not covered if used to enhance athletic performance.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Female-to-male gender reassignment - prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of transgender patients.
Coverage	1 year

Duration	
Other Criteria	Hypogonadism (Primary or Secondary) in Males [Testicular Hypofunction/Low Testosterone with Symptoms] - Approve if pt has had persistent signs and symptoms of androgen deficiency (pre-treatment), has had two pre-treatment serum testosterone (total or bioavailable) measurements, each taken in the morning, on two separate days and the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Female-To-Male (FTM) Gender Reassignment (i.e., Endocrinologic Masculinization) - Approve.

Trelstar	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Advanced Prostate Cancer - Approve.

Viberzi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications not otherwise excluded from coverage
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year

Other Criteria	Irritable bowel syndrome with diarrhea - Approve.

Zileuton	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, previous medication tried
Age Restrictions	12 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Prophylaxis and Chronic Treatment of Persistent Asthma - Approve if pt is using in combination with an orally inhaled corticosteroid and patient has experienced treatment failure or has a contraindication/intolerance to both montelukast and zafirlukast.