Prior Authorization Criteria Updates Effective January 1, 2023

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

On January 1, 2023, prior authorization criteria for the drugs listed below will be updated. These changes will be reflected in the 2023 Prior Authorization Criteria document.

Aubagio	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Non-relapsing forms of MS. Concurrent use of other disease-modifying agents used for MS (examples include interferon beta 1a, interferon beta 1b, glatiramer, peginterferon beta-1a, fingolimod, cladribine, siponomid, dimethyl fumarate DR, ocrelizumab, natalizumab, and alemtuzumab)
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS
Coverage Duration	1 year
Other Criteria	Multiple Sclerosis - Approve if pt has a relapsing form of multiple sclerosis. Continuation - aprove if patient has experienced a beneficial clinical response when assessed by at least one objective measure or experienced stabilization, slowed progreession or improvement in at least one symtom such as motor function, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.

Avonex	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.

Exclusion Criteria	Non-relapsing forms of multiple sclerosis. Concurrent use of other disease-modifying agents used for multiple sclerosis.
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS
Coverage Duration	1 year
Other Criteria	Multiple Sclerosis - Approve if pt has a relapsing form of multiple sclerosis. Continuation - aprove if patient has experienced a beneficial clinical response when assessed by at least one objective measure or experienced stabilization, slowed progreession or improvement in at least one symtom such as motor function, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.

Cibinqo

PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications.
Exclusion Criteria	Concurrent use with a biologic or with a targeted synthetic DMARD, Anti-IL monoclonal antibody, JAK inhibitor, Xolair, or other potent immunosuppressants. COVID-19.
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an allergist, immunologist, or dermatologist
Coverage Duration	Initial - 3 months. Continuation - 1 year

Other Criteria	Atopic Dermatitis (AD) - Approve if pt has had a 3 month trial of at least one traditional systemic therapy, unless intolerant. Continuation - Approve if pt has been established on therapy for at least the initial approval duration and pt experienced a beneficial clinical response from baseline when assessed by at least one objective measure or patient experienced an improvement in at least one symptom.

Dimethyl Fumarate

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	Non-relapsing forms of multiple sclerosis. Concurrent use of other disease-modifying agents used for multiple sclerosis.
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.
Coverage Duration	1 year
Other Criteria	Multiple Sclerosis - Approve if pt has a relapsing form of multiple sclerosis. Continuation - aprove if patient has experienced a beneficial clinical response when assessed by at least one objective measure or experienced stabilization, slowed progreession or improvement in at least one symtom such as motor function, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.

Exkivty

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	
Required	Diagnosis, mutation results, previous therapies tried

Medical Information	
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC) - Approve if pt has locally advanced or metastatic NSCLC, epidermal growth factor receptor (EGFR) exon 20 insertion mutation determined by an approved test, and previously tried at least one platinum-based chemotherapy

Gavreto	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	NSCLC-18 years or older, Thyroid Cancer-12 years or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC) - Approve if pt has metastatic disease and rearranged during transfection (RET) fusion-positive disease as detected by an approved test. Thyroid Cancer - Approve if patient has rearranged during transfection (RET)- fusion positive disease or RET-mutation-positive diease and either the pt has anaplastic thyroid cancer OR the disease requires treatment with systemic therapy and the pt either has medullary thyroid cancer or radioactive iodine-refractory disease.

Gilenya	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion	Concurrent Use with Other Disease-Modifying Agents Used for Multiple

Criteria	Sclerosis (MS). Non-relapsing forms of MS.
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Multiple Sclerosis - Approve if pt has a relapsing form of multiple sclerosis. Continuation - aprove if patient has experienced a beneficial clinical response when assessed by at least one objective measure or experienced stabilization, slowed progreession or improvement in at least one symtom such as motor function, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.

Glatopa	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	Non-relapsing forms of MS. Concurrent use of other disease-modifying agents used for MS (examples include interferon beta 1a, interferon beta 1b, glatiramer, peginterferon beta-1a, fingolimod, cladribine, siponomid, dimethyl fumarate DR, ocrelizumab, natalizumab, and alemtuzumab)
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of MS
Coverage Duration	1 year
Other Criteria	Multiple Sclerosis - Approve if pt has a relapsing form of multiple sclerosis. Continuation - aprove if patient has experienced a beneficial

	clinical response when assessed by at least one objective measure or experienced stabilization, slowed progreession or improvement in at least one symtom such as motor function, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.

Inrebic	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded from coverage. Myeloid/Lymphoid neoplasms with Eosinophilia.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF - Approve if pt has intermediate-2 or high-risk disease. Myeloid/Lymphoid neoplasms - Approve if the pt has eosinophilia and tumor has a JAK2 rearrangement.

Mayzent	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	Non-relapsing forms of multiple sclerosis. Concurrent use of other disease-modifying agents used for multiple sclerosis.
Required Medical Information	Diagnosis
Age Restrictions	

Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.
Coverage Duration	1 year
Other Criteria	Multiple Sclerosis - Approve if pt has a relapsing form of multiple sclerosis. Continuation - aprove if patient has experienced a beneficial clinical response when assessed by at least one objective measure or experienced stabilization, slowed progreession or improvement in at least one symtom such as motor function, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.

Onureg	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Acute Myeloid Leukemia (AML) - Approve if the medication is used for post-remission maintenance therapy, the pt is not able to complete intensive consolidation chemotherapy, the pt has declined or is not fit or eligible for allogeneic hematopoietic stem cell transplant, and the pt meets one of the following: pt has poor- or intermediate-risk cytogenics or pt has complete response to previous intensive induction chemotherapy.

Pemazyre	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	

Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Cholangiocarcinoma - Approve if pt has unresectable locally advanced or metastatic disease with a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an approved test AND the patient has been previously treated with at least one systemic therapy regimen. Myeloid/Lymphoid Neoplasms - Approve if pt has eosinophilia, the cancer has fibroblast growth factor receptor 1 (FGFR1) rearrangement as detected by an approved test, and the cancer is in chronic or blast phase.

Retevmo	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Histiocytic Neoplasm
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	Thyroid Cancer-12 years or older. All others - 18 years or older.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC) - Approve if the pt has advanced, recurrent, or metastatic disease and the tumor is RET fusion-positive. Thyroid Cancer - Approve if the pt has RET fusion-positive or RET mutation-positive disease and the pt has anaplastic thyroid cancer or the disease requires treatment with systemic therapy and the pt has medullary thyroid cancer or the disease is radioactive iodine-refractory. Solid Tumors - Approve it pt has advanced, recurrent, or metastatic disease and the tumor is RET fusion-positive. Histiocytic Neoplasm - Approve if pt has Langerhans cell histiocytosis orr has Erdheim-Chester disease or Rosai-Dorfman disease AND pt has RET fusion.

Rozlytrek	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	NSCLC - 18 year or older. Solid Tumors - 12 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)- Approve if the patient has ROS1-positive metastatic disease detected by an approved test. Solid Tumors - Approve if pt's tumor is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion AND the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity.

Sodium Phenylbutyrate	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Concurrent use with another phenylbutyrate product.
Required Medical Information	Diagnosis, other therapies prescibed, mutation results, lab results
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist
Coverage Duration	Hyperammonemia - 3 months. Genetic mutation in urea cycle disorder - 1 year
Other Criteria	Adjunct treatment of disorder of the urea cycle metabolism - approve if prescribed in conjunction with a protein restricted diet and diagnosis is confirmed by hyperammonemia by lab result over upper limit of the

	normal reference range or genetic testing confirms mutation in urea cycle disorder.

Tiopronin	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, weight
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist, urologist, or physician who specializes in the treatment of cystinuria.
Coverage Duration	1 year
Other Criteria	Cystinuria - Approve if pt weighs 20kg or more and diagnosis of cystinuria has been confirmed based on laboratory testing and the patient has had an inadequate response to high fluid intake, dietary modification, and urinary alkalization, according to the prescriber.

Vitrakvi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, NTRK gene fusion status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Solid tumors - Approve if the tumor has a neurotrophic receptor

	tyrosine kinase (NTRK) gene fusion and the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity.

Vumerity	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	Non-relapsing forms of multiple sclerosis. Concurrent use of other disease-modifying agents used for multiple sclerosis.
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.
Coverage Duration	1 year
Other Criteria	Multiple Sclerosis - Approve if pt has a relapsing form of multiple sclerosis. Continuation - aprove if patient has experienced a beneficial clinical response when assessed by at least one objective measure or experienced stabilization, slowed progreession or improvement in at least one symtom such as motor function, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.

Rebif	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	Non-relapsing forms of multiple sclerosis. Concurrent use of other disease-modifying agents used for multiple sclerosis.
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis.

Coverage Duration	1 year
Other Criteria	Multiple Sclerosis - Approve if pt has a relapsing form of multiple sclerosis. Continuation - aprove if patient has experienced a beneficial clinical response when assessed by at least one objective measure or experienced stabilization, slowed progreession or improvement in at least one symtom such as motor function, vision, bowel/bladder function, spasticity, walking/gait, or pain/numbness/tingling sensation.