people powered health plans

Prior Authorization Criteria Updates Effective February 1, 2023

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

On February 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.

Bexarotene capsule	
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	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	1 year
Other Criteria	Cutaneous T-Cell Lymphoma - Approve if pt has cutaneous manifestations and generic bexarotene capsules are requested or pt has tried genreic bexarotene capsules and pt cannot take generic bexarotene capsules due to a formulation difference in the inactive ingredients between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or a derious adverse reaction.

Bosulif	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Acute Lymphoblastic Leukemia. Myeloid/Lymphoid Neoplasms with Eosinophilia.
Exclusion Criteria	

Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Chronic Myeloid Leukemia - Approve if pt has Philadelphia chromosome positive chronic myeloid leukemia. Acute Lymphoblastic Leukemia - Approve if pt has Philadelphia chromosome-positive acute lymphoblastic leukemia and has tried at least one other tyrosine kinase inhibitor for Philadelphia chromosome-positive acute lymphoblastic leukemia. Myeloid/Lymphoid Neoplasms with Eosinophilia - Approve if tumor has an ABL1 rearrangement.

Glatiramer	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS). Non-relapsing forms of MS.
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.

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

Exclusion Criteria	Concurrent use with other disease modifying agents used for multiple sclerosis. Non-relapsing forms of multiple sclerosis.
Required Medical Information	Diagnosis
Age Restrictions	18 years or older
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.

Nerlynx	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, HER2 status, other therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
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, Recurrent 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.

Penicillamine	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication 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	1 year
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.

Plegridy	
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.