people powered health plans

# Prior Authorization Criteria Updates Effective April 1, 2023

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

On April 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 Gel** | |
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| **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** | 1 year |
| **Other Criteria** | Cutaneous T-Cell Lymphoma - Approve if pt has cutaneous manifestations. |

| **Fingolimod** | |
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| **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** | 10 years or older |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 year |
| **Other Criteria** | Multiple Sclerosis - Approve if pt has a relapsing form of multiple |

| | |
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| | 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. |

| **Rituxan Hycela** | |
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| **PA Criteria** | **Criteria Details** |
| **Covered Uses** | All FDA-approved indications not otherwise excluded. Hairy Cell Leukemia. Hodgkin Lymphoma. Waldenstroms Macroglobulinemia/Lymphoplasmacytic Lymphoma. |
| **Exclusion Criteria** | Granulomatosis with Polyangiitis (Wegeners granulomatosis) or Microscopic Polyangiitis. Pemphigus Vulgaris. Rheumatoid Arthritis. |
| **Required Medical Information** | Diagnosis, previous rituximab use |
| **Age Restrictions** | 18 years or older |
| **Prescriber Restrictions** | Prescribed by or in consultation with an oncologist. |
| **Coverage Duration** | 1 year |
| **Other Criteria** | Approve if pt has already received at least one full dose of rituximab intravenous AND Rituxan Hycela is administered under the care of a healthcare professional. |