people powered health plans

Prior Authorization Criteria Updates Effective July 1, 2021

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

On July 1, 2021, prior authorization criteria for the drugs listed below will be updated. These changes will be reflected in the 2021 Prior Authorization Criteria document.

Actemra	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Polymyalgia Rheumatica.
Exclusion Criteria	Concurrent Use with a Biologic Disease-Modifying Antirheumatic Drug (DMARD) or Targeted Synthetic DMARD. Crohn's disease. COVID-19.
Required Medical Information	Diagnosis and other medications tried for the diagnosis provided
Age Restrictions	PJIA/SJIA - 2 years of age and older. All other conditions - 18 years of age and older.
Prescriber Restrictions	RA/PJIA/SJIA/PMR/GCA - Prescribed by or in consultation with a rheumatologist. ILD - Prescribed by or in consultation with a rheumatologist or a pulmonologist.
Coverage Duration	ILD - 1 yr. GCA/PMR - 6 mo. RA/SJIA - 3 mo. PJIA - 4 mo. Continuation - 1 yr.
Other Criteria	Giant Cell Arteritis (GCA) - approve if pt has tried one systemic corticosteroid (e.g. prednisone). Interstitial Lung Disease Associated with Systemic Sclerosis (ILD) - approve if pt has elevated acute phase reactants (C-reactive protein (CRP) ≥ 6 mg/mL, erythrocyte sedimentation rate (ESR) ≥ 28 mm/h, or platelet count ≥ 330 x 109/L), forced vital capacity (FVC) is greater than 55% of the predicted value, and diagnosis is confirmed by high-resolution computed tomography. Polyarticular Juvenile Idiopathic Arthritis (PJIA) - approve if the patient has tried a specific biologic DMARD (Humira, Enbrel, an infliximab product, or Simponi Aria) OR the pt has heart failure or a previously treated lymphoproliferative disorder. Rheumatoid Arthritis (RA) - approve if the patient has tried a specific biologic DMARD (Humira, Cimzia, Enbrel, an infliximab product, or Simponi) OR the pt has heart failure or a previously treated lymphoproliferative disorder. Systemic Juvenile Idiopathic Arthritis (SJIA) - approve if the patient has tried ONE other systemic agent for

	this condition (e.g., a corticosteroid, a conventional synthetic DMARD, or a 1-month trial of an NSAID). Polymyalgia Rheumatica (PMR) - approve if the patient has tried one systemic corticosteroid (e.g., prednisone). Continuation RA/PJIA - approve if patient has had a response to therapy, as determined by the prescriber AND pt has been taking Actemra for at least 90 days. Continuation ILD - approve if pt had adequate efficacy, demonstrated by a 10% decrease or less in predicted FVC over the past year while on Actemra. Continuation for other conditions - approve if patient has had a response to therapy, as determined by the prescriber.

Aimovig	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Combination use with other prophylactic CGRP agents. Acute treatment of migraines. Cluster headache. Hemiplegic migraine.
Required Medical Information	Diagnosis, number of migraine headaches per month, prior therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Migraine Headache Prevention - Pt has 4 or more migraine headache days per month (prior to initiating a migraine-preventative medication), and has tried at least two prophylactic pharmacologic therapies from different classes (e.g., tricyclic antidepressant, beta-blocker) and had an inadequate response or adverse events, according to the prescriber. Pt must also have also tried triptan therapy, unless contraindicated according to the prescriber, unless pt is currently taking a CGRP inhibiotr for migraine headache prevention and has had a significant clinical benefit from the medication as determined by the prescriber.

Ajovy	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Combination use with other prophylactic CGRP agents. Acute treatment of migraines. Cluster headache.
Required	Diagnosis, number of migraine headaches per month, prior therapies

Medical Information	tried
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Migraine Headache Prevention - Pt has 4 or more migraine headache days per month (prior to initiating a migraine-preventative medication), and has tried at least two prophylactic pharmacologic therapies from different classes (e.g., tricyclic antidepressant, beta-blocker) and had an inadequate response or adverse events, according to the prescriber. Pt must also have also tried triptan therapy, unless contraindicated according to the prescriber, unless pt is currently taking a CGRP inhibiotr for migraine headache prevention and has had a significant clinical benefit from the medication as determined by the prescriber.

Arcalyst	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use with other biologic therapies for an inflammatory condition. COVID-19
Required Medical Information	Diagnosis, genetic testing
Age Restrictions	CAPS/Pericarditis - 12 years and older
Prescriber Restrictions	CAPS - Prescribed by or in consultation with a rheumatologist, geneticist, allergist/immunologist, or dermatologist. IL-1 RA- Prescribed by or in consultation with a rheumatologist, geneticist, dermatologist, or a physician specializing in the treatment of autoinflammatory disorders.
Coverage Duration	CAPS/Pericarditis initial - 3 mo. IL-1 RA initial - 6 mo. Cont for CAPS/IL-1 RA - 3 yrs. Cont for Pericarditis - 1 yr.
Other Criteria	Cryopyrin-Associated Periodic Syndromes (CAPS) [Familial Cold Autoinflammatory Syndrome, Muckle-Wells Syndrome, and Neonatal Onset Multisystem Inflammatory Disease or chronic infantile neurological cutaneous and articular syndrome]- Initial - Approve. Deficiency of Interleukin-1 Receptor Antagonist (IL-1 RA)- Initial - approve if pt is greater than 10 kg (22 lbs) AND genetic testing has confirmed a mutation in the IL1RN gene and according to the prescriber, patient has demonstrated a clinical benefit with Kineret.

	Pericarditis - Approve if pt has recurrent pericarditis with a history of at least three episodes of pericarditits in the past year AND pt is currently receiving standard treatment or standard treatment is contraindicated. Continuation for all - Approve it pt has responded to therapy, as determined by prescriber.

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
Age Restrictions	Chronic Myeloid Leukemia, Acute Lymphoblastic Leukemia - 18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
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. (e.g., imatinib and dasatinib). Myeloid/Lymphoid Neoplasms with Eosinophilia - approve if tumor has an ABL1 rearrangement.

Emgality	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Combination use with other prophylactic CGRP agents. Acute treatment of migraines.
Required Medical Information	Diagnosis, number of migraine headaches per month, prior therapies tried
Age	18 years or older

Restrictions	
Prescriber Restrictions	
Coverage Duration	Cluster Headaches - 6 months. Migraine Prevention - 1 year.
Other Criteria	Episodic Cluster Headache Treatment - Approve if pt has 1 to 8 headaches per day and has tried at least one standard prophylactive pharmacologic therapy for cluster headache. Migraine Headache Prevention - Pt has 4 or more migraine headache days per month (prior to initiating a migraine-preventative medication), and has tried at least two prophylactic pharmacologic therapies from different classes (e.g., tricyclic antidepressant, beta-blocker) and had an inadequate response or adverse events, according to the prescriber. Pt must also have also tried triptan therapy, unless contraindicated according to the prescriber, unless pt is currently taking a CGRP inhibiotr for migraine headache prevention and has had a significant clinical benefit from the medication as determined by the prescriber.

Gleevec	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. All FDA approved indications not otherwise excluded. Chordoma. Fibromatosis (Desmoid Tumors). Graft Versus Host Disease, Chronic. Kaposi Sarcoma. Metastatic Melanoma. Myeloid/Lymphoid Neoplasms with Eosinophilia. Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor.
Exclusion Criteria	
Required Medical Information	Diagnosis. Mutation results.
Age Restrictions	ASM/DP/HS/MDD - 18 or older.
Prescriber Restrictions	
Coverage Duration	Graft Versus Host Disease, Chronic - 1 year. All others - 3 years
Other Criteria	Acute Lymphoblastic Leukemia - approve if pt has Philadelphia chromosome-positive acute lymphoblastic leukemia. Aggressive Systemic Mastocytosis (AMS) - approve. Chronic Myeloid Leukemia - approve if pt has Philadelphia chromosome-positive chronic myeloid leukemia. Dermatofibrosarcoma Protuberans (DP) - approve. Gastrointestinal Stromal Tumors - approve. Hypereosinophilic Syndrome and/or Chronic Eosinophilic Leukemia (HS) - approve. Myelodysplastic/Myeloproliferative Disease (MDD) - approve if condition is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements. Chordoma - approve. Fibromatosis

	(Desmoid Tumors) - approve if pt has advanced, aggressive, or unresectable fibromatosis (desmoid tumors). Graft Versus Host Disease, Chronic - approve if pt has tried at least one conventional systemic treatment for graft versus host disease. Kaposi Sarcoma - approve if pt has tried at least one medication and has relapsed or refractory disease. Metastatic Melanoma - approve if pt has c-Kit-positive advanced/recurrent or metastatic melanoma. Myeloid/Lymphoid Neoplasms with Eosinophilia - approve if pt has tumor has an ABL1, FIP1L1-PDGFRA or PDGFRB rearrangement. Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor - Approve if pt has tried Turalio (pexidartinib capsules) or cannot take Turalio, according to the prescriber.

Hemlibra	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	lab results, other medications tried
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hemophilia specialist
Coverage Duration	1 year
Other Criteria	Hemophilia A with Factor VIII Inhibitors - Approve if pt is using Hemlibra for routine prophylaxis to prevent or reduce the frequency of bleeding episodes AND either has had a positive Factor VIII inhibitor titer greater than 5 Bethesda Units OR has had a positive Factor VIII inhibitor titer less than or equal to 5 Bethesda Units with an anamnestic response (current or past) to Factor VIII product dosing or experienced an inadequate clinical response (current or past) to increased Factor VIII product dosing. Presciber also attests that the patient will not be undergoing immune tolerance induction therapy while receiving Hemlibra, that if the patient is currently receiving a bypassing agent for prophylaxis, the bypassing agent therapy will be discontinued the day prior to initiation of Hemlibra and prophylactic use of bypassing agents will not occur while using Hemlibra, AND if the pt is currently receiving a Factor VIII product for prophylactic use, the Factor VIII product will be discontinued within the initial 4-week loading dose period with Hemlibra and that prophylactic use of Factor VIII products will not occur while using Hemlibra. Continuation - prescriber must make Factor VIII and bypassing agent attestations and the pt must have experienced a beneficial response, according to prescriber.

	Hemophilia A without Factor VIII Inhibitors - Approve if pt is using Hemlibra for routine prophylaxis to prevent or reduce the frequency of bleeding episodes AND has severe to moderate severe disease as defined by pretreatment Factor VIII levels ≤ 2% of normal OR has moderate to mild disease as defined by pretreatment Factor VIII levels greater than 2% to less than 40% of normal and meets one of the following criteria: pt has experienced a severe, traumatic, or spontaneous bleeding episode as determined by the prescriber, has hemophilia-related joint damage, has experienced a joint bleed, or has a specific joint that is subject to recurrent bleeding (presence of a target joint), or is in a perioperative situation and/or has an additional clinical scenario regarding bleeding/bleeding risk in which the prescriber determines the use of Hemlibra is warranted. Prescriber also attests that prophylactic use of bypassing agent will not occur while using Hemlibra, that if pt is receiving a Factor VIII product for prophylactic use, therapy will be discontinued within the initial 4-week loading dose period with Hemlibra, and prophylactic use of Factor VIII products will not occur while using Hemlibra. Continuation - prescriber must make Factor VIII and bypassing agent attestations and the pt must have experienced a beneficial response, according to prescriber.

Iclusig	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Myeloid/Lymphoid Neoplasms with Eosinophilia.
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	Chronic Myeloid Leukemia, Acute Lymphoblastic Leukemia - 18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Acute Lymphoblastic Leukemia - approve if pt has Philadelphia chromosome-positive acute lymphoblastic leukemia and has tried at least two other tyrosine kinase inhibitors for Philadelphia chromosome-positive acute lymphoblastic leukemia. (e.g., imatinib and dasatinib). Chronic Myeloid Leukemia - approve if pt has Philadelphia chromosome positive chronic myeloid leukemia and has tried at least two other tyrosine kinase inhibitors for Philadelphia chromosome-positive chronic myeloid leukemia. (e.g., imatinib, dasatinib, or nilotinib). Myeloid/Lymphoid Neoplasms with

	Eosinophilia - approve if tumor has an ABL1 or FGFR1 rearrangement.

Jakafi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Acute Lymphoblastic Leukemia. Atypical Chronic Myeloid Leukemia. Chronic Monomyelocytic Leukemia-2. Graft versus Host Disease, Chronic.
Exclusion Criteria	
Required Medical Information	Previous therapies tried. Mutation results.
Age Restrictions	GVHD - 12 years or older. MF/PV/CML-2 - 18 years or older. ALL - 21 years or older.
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Graft versus Host Disease, Acute - Approve if pt has tried one systemic corticosteroid. Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF - approve. Polycythemia Vera (PV) - approve if pt has tried hydroxyurea. Acute Lymphoblastic Leukemia (ALL) - Approve if the mutation/pathway is Janus Associated Kinase-related. Atypical Chronic Myeloid Leukemia - approve if pt has a Janus Associated Kinase mutation. Chronic Monomyelocytic Leukemia-2 - approve if pt is also receiving a hypomethylating agent. Graft versus Host Disease, Chronic - Approve if pt has tried one conventional systemic treatment for graft versus host disease.

Natpara	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Acute post-surgical hypoparathyroidism.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.

Coverage Duration	3 years
Other Criteria	Chronic hypoparathyroidism - Before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician AND as per product labeling, patient cannot be well-controlled on calcium supplements and active forms of vitamin D alone. Continuation - The patient cannot be well-controlled on calcium supplements and active forms of vitamin D alone, pt's 25-hydroxyvitamin D stores are sufficient during Natpara therapy, according to the prescriber, and pt is responding to Natpara therapy, according to the prescriber.

Natpara	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Acute post-surgical hypoparathyroidism.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	3 years
Other Criteria	Chronic hypoparathyroidism - Before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician AND as per product labeling, patient cannot be well-controlled on calcium supplements and active forms of vitamin D alone. Continuation - The patient cannot be well-controlled on calcium supplements and active forms of vitamin D alone, pt's 25-hydroxyvitamin D stores are sufficient during Natpara therapy, according to the prescriber, and pt is responding to Natpara therapy, according to the prescriber.

Pomalyst	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Central Nervous System Lymphoma. POEMS Syndrome. Systemic Light Chain Amyloidosis.
Exclusion Criteria	
Required	

Medical Information	
Age Restrictions	KS/MM/POEMS/SLCA - 18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Kaposi Sarcoma (KS) - approve if pt is HIV negative OR if pt is HIV positive and continues to receive highly active antiretroviral therapy. Multiple Myeloma (MM) - Approve if pt has received at least one other Revlimid (lenalidomide tablets)-containing regimen. Central Nervous System Lymphoma - approve if pt has relapsed or refractory disease. POEMS Syndrome - approve if Pomalyst is in combination with dexamethasone. Systemic Light Chain Amyloidosis (SLCA) - approve if Pomalyst is in combination with dexamethasone and pt has tried at least one other regimen.

Revlimid	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. B Cell Lymphomas. Kaposi Sarcoma. Castleman's Disease. Central Nervous System Lymphoma. Classical Hodgkin Lymphoma. Langerhans Cell Histiocytosis. Myelofibroisis. Peripheral T-Cell Lymphomas. POEMS Syndrome. Systemic Light Chain Amyloidosis. T-Cell Leukemia/Lymphoma.
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies tried, other medications, lab results
Age Restrictions	FL/MCL/MZL/MM/MDS/BCL/CHL/MF/PTCL/POEMS/SLCA/TCL - 18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Follicular Lymphoma (FL) - approve if pt is using Revlimid in combination with rituximab or pt has tried at least one other regimen. Mantle Cell Lymphoma (MCL) - Approve if pt is using Revlimid in combination with rituximab or pt has tried at least two other regimens. Marginal Zone Lymphoma (MZL) - is using Revlimid in combination with rituximab or pt has tried at least one other regimen. Multiple Myeloma (MM) - approve. Myelodysplastic Syndrome (MDS) - approve if pt has symptomatic anemia, has transfusion-dependent anemia, or has anemia that is not controlled with an erythroid

	stimulating agent. B-Cell Lymphomas, Other (BCL) - Approve if pt has tried at least one other regimen. Kaposi Sarcoma - approve if pt has relapsed or refractory disease and has tried at least one other medication. Castleman's Disease - apporve if pt has relapsed/refractory or progressive disease. Central Nervous System Lymphoma - approve if prescriber attests that pt has relapsed or refractory disease. Classical Hodgkin Lymphoma (CHL) - approve if pt has tried at least one other regimen. Langerhans Cell Histiocytosis - approve if pt has multifocal skin disease. Myelofibrosis (MF) - approve if pt has anemia, according to prescriber AND either pt has serum erythropoietin levels greater than 500 mU/mL OR pt has serum erythropoietin levels less than 500 mU/mL and has experienced no response or loss of response to an erythropoiesis-stimulating stimulating agent. Peripheral T-Cell Lymphomas - approve if pt has tried at least one other regimen. POEMS syndrome - approve if Revlimid is used in combination with dexamethasone. Systemic Light Chain Amyloidosis (SLCA) - Approve if Revlimid is used in combination with dexamethasone. T-Cell Leukemia/Lymphoma - approve if pt has tried one other regimen.

Spravato	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications
Exclusion Criteria	
Required Medical Information	Prior therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by a psychiatrist
Coverage Duration	SI - 2 months. TRD - 6 months.
Other Criteria	Major Depressive Disorder with Acute Suicidal Ideation or Behavior (SI) - Pt has major depressive disorder that is considered to be severe, according to the prescriber AND pt is concomitantly receiving at least one oral antidepressant AND pt has no history of psychosis or the prescriber believes that the benefits of Spravato outweigh the risks. Treatment-Resistant Depression - Pt has demonstrated nonresponse (greater than 25% improvement in depression symptoms or scores) to at least two different antidepressants, each from a different pharmacologic class, according to the prescriber AND each antidepressant was used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescriber AND pt is concomitantly receiving at least one oral antidepressant AND pt has no history of psychosis OR the prescriber believes that the benefits of Spravato outweigh the risks AND pts

	history of controlled substance prescriptions has been checked using the state prescription drug monitoring program, according to the prescriber.

Sprycel	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Chondrosarcoma or Chordoma. Gastrointestinal Stromal Tumor. Myeloid/Lymphoid Neoplasms with Eosinophilia.
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	Gastrointestinal Stromal Tumor, Meyloid/Lymphoid Neoplasms with Eosinophilia - 18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Acute Lymphoblastic Leukemia - approve if pt has Philadelphia chromosome-positive acute lymphoblastic leukemia. Chronic Myeloid Leukemia - approve if pt has Philadelphia chromosome positive chronic myeloid leukemia. Chondrosarcoma or Chordoma - approve. Gastrointestinal Stromal Tumor - approve if pt has tried at least three other medications for this indication. Myeloid/Lymphoid Neoplasms with Eosinophilia - approve if tumor has an ABL1 rearrangement. interferon-based therapy for HCV. TMDS - Approve if pt has low to intermediate risk MDS and pt either has platelet count of less than 30,000/mL or less than 50,000/mL and pt is at risk for bleeding according to prescriber. AA Continuation - approve if pt demonstrates a beneficial clinical response according to prescriber. CIT, TMDS Cont. - approve if pt demonstrates a beneficial clinical response according to prescriber and pt remains at risk for bleeding complications.

Tasigna	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Acute Lymphoblastic Leukemia. Gastrointestinal Stromal Tumor. Myeloid/Lymphoid Neoplasms with Eosinophilia.
Exclusion Criteria	
Required	Diagnosis, previous therapies

Medical Information	
Age Restrictions	Acute Lymphoblastic Leukemia, Gastrointestinal Stromal Tumor, Meyloid/Lymphoid Neoplasms with Eosinophilia - 18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
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 inhibitors for Philadelphia chromosome-positive acute lymphoblastic leukemia. (e.g., imatinib and dasatinib). Gastrointestinal Stromal Tumor - approve if pt has tried at least three other medications for this indication. Myeloid/Lymphoid Neoplasms with Eosinophilia - approve if tumor has an ABL1 rearrangement.

Thalomid	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Castleman's Disease. Discoid Lupus Erythematosus or Cutaneous Lupus Erythematosus. Kaposi Sarcoma. Langerhans Cell Histiocytosis. Myelofibrosis. Prurigo Nodularis. Recurrent Aphthous Ulcers or Aphthous Stomatitis. Rosai-Dorfman Disease.
Exclusion Criteria	Cancer Cachexia. Crohn's Disease.
Required Medical Information	Diagnosis, previous therapies tried, other medications, lab results
Age Restrictions	Multiple Myeloma, Myelofibrosis - 18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Erythema nodosum Leprosum - approve. Multiple Myeloma - approve if Thalomid is being taken in combination with at least two other medications. Castleman's Disease - approve if pt relapsed/refractory or progressive disease OR pt has multi-centric Castleman’s Disease and is negative for the human immunodeficiency virus and human herpesvirus-8. Discoid Lupus Erythematosus or Cutaneous Lupus Erythematosus - approve if pt has tried at least two other medications. Kaposi Sarcoma - approve if pt has tried at least one other medication. Langerhans Cell Histiocytosis - approve if pt has multifocal skin disease. Myelofibrosis - approve if pt has anemia, according to prescriber AND either pt has serum erythropoietin levels

	greater than 500 mU/mL OR pt has serum erythropoietin levels less than 500 mU/mL and has experienced no response or loss of response to an erythropoiesis-stimulating stimulating agent. Prurigo Nodularis - approve if pt has tried at least two other medications. Recurrent Aphthous Ulcers or Aphthous Stomatitis - approve if pt has tried at least two other medications. Rosai-Dorfman Disease - approve if pt has cutaneous disease.

Tobramycin (nebulized)	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Bronchiectasis, Non-Cystic Fibrosis.`
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Bronchiectasis - 18 years or older
Prescriber Restrictions	CF - prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis. Bronchiectasis - prescribed by or in consultation with a pulmonologist.
Coverage Duration	1 year
Other Criteria	Cystic Fibrosis (CF) - Approve if pt has Pseudomonas aeruginosa in culture of the airway. Bronchiectasis, Non-Cystic Fibrosis - Approve if pt has Pseudomonas aeruginosa in culture of the airway.

Xifaxan	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Helicobacter pylori Infection
Required Medical Information	other medications used
Age	Hepatic Encephalopathy/IBSD - 18 years or older. Traveler's Diarrhea

Restrictions	- 12 years or older.
Prescriber Restrictions	
Coverage Duration	Hepathic Encephalopathy - 6 mo. IBSD/SIBO - 14 days. Traveler's Diarrhea - 3 days.
Other Criteria	Hepatic Encephalopathy - Approve if pt has previously had overt hepatic encephalopathy, according to the prescriber, and Xifaxin will be used concomitantly with lactulose, unless pt has a contraindication or significant intolerance to treatment with lactulose (550mg tablets only). Irritable Bowel Syndrome with Diarrhea (IBSD) - approve (550mg tablets only). Traveler's Diarrhea - Approve if pt is afebrile and does not have blood in the stool (200mg tablets only). Small Intestine Bacterial Overgrowth (SIBO) - approve if SIBO is diagnosed by glucose hydrogen breath test, lactulose hydrogen breath test, or small bowel aspiration and culture.