Prior Authorization Criteria Updates Effective August 1, 2022

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

On August 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.

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	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. Myeloid/Lymphoid Neoplasms with Eosinophilia - Approve if tumor has an ABL1 rearrangement.

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	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. Chronic Myeloid Leukemia - Approve if pt has Philadelphia chromosome positive chronic myeloid leukemia and either has tried at least two other tyrosine kinase inhibitors for Philadelphia chromosome-positive chronic myeloid leukemia or the chronic myeloid leukemia is T315I-positive. Myeloid/Lymphoid Neoplasms with Eosinophilia - Approve if tumor has an ABL1 or FGFR1 rearrangement.

Natpara	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Acute post-surgical hypoparathyroidism. Hypoparathyroidism Caused by Calcium-Sensing Receptor Mutations
Required Medical Information	Diagnosis, lab results
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, 25-hydroxyvitamin D stores are sufficient per the prescribing physician, and pt 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.

Pemazyre	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
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, and the cancer is in chronic or blast phase.

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	diagnosis, other therapies tried
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.

Tukysa	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, other therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Breast Cancer- Approve if the pt has recurrent or metastatic breast cancer, human epidermal growth factor receptor 2 (HER2)-positive disease, has received at least one prior anti-HER2-based regimen in the metastatic setting, and the medication is used in combination with trastuzumab and capecitabine.