people powered health plans

Prior Authorization Criteria Updates Effective September 1, 2021

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

On September 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.

Benlysta	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use with other biologics. Rheumatoid Arthritis.
Required Medical Information	Diagnosis, lab results, other therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	LN - Prescribed by or in consultation with a nephrologist or rheumatologist. SLE - Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist, or dermatologist.
Coverage Duration	LN initial - 6 mo. SLE initial - 4 mo. Continuation - 1 year.
Other Criteria	Lupus Nephritis (LN) - Approve if pt has autoantibody-positive SLE, defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA (anti-dsDNA) antibody and the medication is being used concurrently with at least one other standard therapy, unless intolerant as determined by the prescriber. Continuation - Approve if pt has responded to Benlysta and the medication is being used concurrently with at least one other standard therapy, unless intolerant, as determined by the prescriber. Systemic Lupus Erythematosus (SLE) - Approve if pt has autoantibody-positive SLE, defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA (anti-dsDNA) antibody and the medication is being used concurrently with at least one other standard therapy, unless intolerant as determined by the prescriber. Continuation - Approve if pt has responded to Benlysta and the medication is being used concurrently with at least one other standard therapy, unless intolerant, as determined by the prescriber.

Caprelsa	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Differentiated Thyroid Carcinoma. Non-Small Cell Lung Cancer.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Medullary Thyroid Cancer - approve. Differentiated Thyroid Carcinoma (i.e., papillary, follicular, and Hürthle)- approve if refractory to radioactive iodine therapy. Non-Small Cell Lung Cancer - approve if tumor has RET gene rearrangements.

Cometriq	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Differentiated Thyroid Carcinoma. Non-Small Cell Lung Cancer.
Exclusion Criteria	Metastatic Castration-Resistant Prostate Cancer
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Medullary Thyroid Cancer - approve. Differentiated Thyroid Carcinoma (i.e., papillary, follicular, and Hürthle)- approve if refractory to radioactive iodine therapy. Non-Small Cell Lung Cancer - approve if pt has RET gene rearrangements.

Sofosbuvir-Velpatasvir	
PA Criteria	**Criteria Details**

Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin. Life expectancy less than 12 months due to non-liver related comorbidities. Pediatric patients less than 6 years of age or less than 17 kg.
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Criteria will be applied according to AASLD guidelines.

Inlyta	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Differentiated Thyroid Carcinoma.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Advanced Renal Cell Carcinoma - Approve. Differentiated Thyroid Cancer (examples include papillary, follicular, and Hürthle cell thyroid carcinoma) - Approve if patient is refractory to radioactive iodine therapy.

Lenvima	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Medullary thyroid carcinoma. Thymic Carcinoma.

Exclusion Criteria	
Required Medical Information	Diagnosis, previous tried therapies
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Endometrial Carcinoma - Approve if pt has advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) and is used in combination with Keytruda, after pt has tried at least one systemic therapy and is not a candidate for curative surgery or radiation. Hepatocellular Cancer - Approve if pt has unresectable or metastatic disease. Renal Cell Cancer - Approve if pt has relapsed or refractory disease, and pt either has 1) clear cell histology and Lenvima is used in combination with Keytruda OR pt has tried one antiangiogenic therapy and Lenvima is being used in combination with everolimus or 2) non-clear cell histology and Lenvima is used in combination with everolimus. Thyroid Carcinoma, Differentiated (papillary, follicular, and Hürthle cell) - Approve if disease is refractory to radioactive iodine therapy. Thymic Carcinoma - Approve if pt has tried at least one chemotherapy regimen. Medullary Thyroid Carcinoma - Approve if pt has tried at least one systemic therapy.

Oriahnn	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Heavy Menstrual Bleeding not associated with Uterine Fibroids
Required Medical Information	Diagnosis, previous therapies, test results
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an obstetrician-gynecologist or a health care practitioner who specializes in the treatment of women's health
Coverage Duration	2 years
Other Criteria	Uterine Fibroids (Leiomyomas) - Approve if pt is premenopausal and experiencing heavy menstrual bleeding associated with the uterine

	fibroids which have been confirmed by a pelvic ultrasound, including transvaginal ultrasonography or sonohysterography; hysteroscopy; or magnetic resonance imaging. Pt must also have tried at least one other therapy for the medical management of heavy menstrual bleeding, and pt has not previously received 24 months or longer of therapy with Oriahnn or Myfembree.

Tepmetko	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Non-Small Cell Lung Cancer - Approve if pt has metastatic disease and the tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping alterations.