people powered health plans

Prior Authorization Criteria Updates Effective September 1, 2022

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

On September 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.

Haegarda	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concomitant use with other HAE prophylactic therapies. Patients may concomitantly use medications for the treatment of acute HAE attacks.
Required Medical Information	diagnosis, lab values
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders.
Coverage Duration	1 year
Other Criteria	Hereditary Angioedema (HAE) - HAE type 1 or type 2 as confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline AND lower than normal serum C4 levels at baseline. A diagnosis of HAE with normal C1-INH (also referred to as HAE type III) does NOT satisfy this requirement. [documentation required] Continuation therapy - patient is currently receiving Haegarda for HAE type 1 or type 2 prophylaxis AND according to the prescriber, the patient has had a favorable clinical response (e.g., decrease in number of HAE acute attack frequency, decrease in HAE attack severity, decrease in duration of HAE attacks) since initiating Haegarda prophylactic therapy compared with baseline.

Icatibant	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded
Exclusion Criteria	HAE Prophylaxis
Required Medical Information	Diagnosis, lab results
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an allergist/immunologist or a physican that specializes in the treatment of HAE or related disorders.
Coverage Duration	1 year
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency (Type I or Type II), Treatment of Acute Attacks - Approve if pt has HAE type 1 or 2 as confrimed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and pt has lower than normal serum C4 levels at baseline. A diagnosis of HAE with normal C1-INH (also referred to as HAE type III) does NOT satisfy this requirement. [documentation required] Continuation - Approve if pt has treated previous acute HAE type 1 or 2 attacks with icatibant and according to the prescriber, the pt has had a favorable response with icatibant treatment.

Orladeyo	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications not otherwise excluded.
Exclusion Criteria	Concomitant Use with Other HAE Prophylactic Therapies
Required Medical Information	diagnosis, lab results
Age Restrictions	12 years or older
Prescriber Restrictions	prescribed by or in consultation with an allergist/immunologist or a physician who specializes in the treatment of HAE or related disorders.
Coverage	1 year

Duration	
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] Prophylaxis - Approve if pt has HAE type I or type II as confirmed by low levels of functional C1-INH protein (less than 50% of normal) and lower than normal serum C4 levels at baseline, as defined by the laboratory reference values. A diagnosis of HAE with normal C1-INH (also referred to as HAE type III) does NOT satisfy this requirement. [documentation required] Continuation - Approve if pt has a diagnosis of HAE type I or II [documentation required] and according to the prescriber, the patient has had a favorable clinical response since initiating Orladeyo prophylactic therapy compared with baseline.

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 Medical Information	Diagnosis, previous therapies tried
Age Restrictions	Acute Lymphoblastic Leukemia, Gastrointestinal Stromal Tumor, Meyloid/Lymphoid Neoplasms with Eosinophilia - 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 inhibitors for Philadelphia chromosome-positive acute lymphoblastic leukemia. (e.g., imatinib and dasatinib). Gastrointestinal Stromal Tumor - Approve if pt has tried imatinib or avapritinib, sunitinib or dasatinib, regorafinib, and ripretinib. Myeloid/Lymphoid Neoplasms with Eosinophilia - Approve if tumor has an ABL1 rearrangement. Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor - Approve if pt has tried pexidartinib or pt cannot take pexidartinib, according to the prescriber.

Teriparatide	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use with other medications for osteoporosis (Prolia, oral bisphosphonates, calcitonin nasal spray, Tymlos, and Evenity)(VitD and Calcium not excluded from concurrent therapy). Osteoporosis prevention.
Required Medical Information	diagnosis, other therapies tried, lab results
Age Restrictions	
Prescriber Restrictions	Hypoparathyroidism - prescribed by or in consultation with an endocrinologist
Coverage Duration	All Osteoporosis: Initial or less than 1 year: up to 2 years. Continuation: 1 year. HPT - 1 year
Other Criteria	Glucocorticoid-Induced Osteoporosis, Treatment - approve if pt is either initiating or continuing systemic glucocorticoids and meets one of the following: pt has tried zoledronic acid injection OR has tried at least one oral bisphosphonate or oral bisphosphonate-containing product and had an osteoporotic fracture or fragility fracture while receiving oral bisphosphonate therapy or experienced inadequate efficacy to oral bisphosphonate therapy after a trial duration of 12 months as determined by the prescriber or has experienced significant intolerance to an oral bisphosphonate OR pt cannot take an oral bisphosphonate due to difficulty swallowing or inability to remain upright, or pt has a pre-existing gastrointestinal medical condition OR pt has severe renal impairment, chronic kidney disease, or has had an osteoporotic fracture or a fragility fracture. Use beyond 2 years is evaluated annually for continued high risk of fracture. Not at high risk of fracture - up to 2 years/lifetime. Osteoporosis, Treatment for a Postmenopausal Patient and Osteoporosis, (to Increase Bone Mass) in Men with Primary or Hypogonadal Osteoporosis - Approve if pt has had a T-score at or below -2.5 at the lumbar spine, femoral neck, total hip and/or 33% radius, has had an osteoporotic fracture or a fragility fracture, or has low bone mass and is at risk for fracture. Pt also meets one of the following: pt has tried ibandronate injection (Postmenopausal pts only) or zoledronic acid injection OR has tried at least one oral bisphosphonate or oral bisphosphonate-containing product and had an osteoporotic fracture or fragility fracture while receiving oral bisphosphonate therapy or experienced inadequate efficacy to oral bisphosphonate therapy after a trial duration of 12 months as determined by the prescriber or has experienced significant intolerance to an oral bisphosphonate OR pt cannot take an

	oral bisphosphonate due to difficulty swallowing or inability to remain upright, or pt has a pre-existing gastrointestinal medical condition OR pt has severe renal impairment, chronic kidney disease, or has had an osteoporotic fracture or a fragility fracture. Use beyond 2 years is evaluated annually for continued high risk of fracture. Not at high risk of fracture - up to 2 years/lifetime. Hypoparathyroidism (HPT) - Approve if pt has tried Natpara or Natpara is unavailable.