people powered health plans

Prior Authorization Criteria Updates Effective October 1, 2021

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

On October 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.

Afinitor	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Differentiated Thyroid Carcinoma, Ednometrial Carcinoma, Gastrointestinal Stromal Tumors (GIST), Classical Hodkin Lymphoma, Meningioma, Soft Tissue Sarcoma – Perivascular Epitheloid Cell Tumors (PEComa), Recurrent Angiomyolipoma, Lymphangioleiomyomatosis. Thymomas and Thymic Carcinomas. Waldenström's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL).
Exclusion Criteria	
Required Medical Information	diagnosis, hormone receptor status, prior therapies
Age Restrictions	Breast cancer/NE tumors/RCC/TSC with RA/TC/EC/GIST/CHL/Meningioma/STS/TTC/WM/LPL - 18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Breast Cancer - patient has recurrent or Stage IV, hormone receptor Positive (HR+) disease and human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND the pt has tried at least one prior endocrine therapy (anastrazole, letrozole, or tamoxifen), AND pt meets one of the following: pt is a postmenopausal female OR male OR pt is pre-or perimenopausal and is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist (e.g., leuprolide, triptorelin, goserelin), or has had surgical bilateral oophorectomy or ovarian irradiation AND pt meets one of the following: if pt is a male and if Afinitor will be used in combination with exemestane, then the patient is receiving a GnRH agonist OR Afinitor will be used in combination with exemestane, fulvestrant or tamoxifen AND the pt has not had disease progression while on

	Afinitor. Advanced, Unresectable or Metastatic Carcinoid Tumors - Approve. Renal Cell Carcinoma (RCC) - Pt has relapsed or stage IV disease. If using for clear cell disease, the pt has tried a systemic therapy previously (e.g. axitinib, pazopanib, sunitinib, cabozantinib, sorafenib). Tuberous Sclerosis Complex (TSC)-Associated Renal Angiomyolipoma - approve. TSC-Associated Subependymal Giant Cell Astrocytoma (SEGA) - Approve if SEGA cannot be curatively resected. TSC-Associated Partial Onset Seizure - approve. Differentiated Thyroid Carcinoma -Approve if refractory to radioactive iodine therapy. Endometrial Carcinoma - Pt has recurrent, metastatic, or high-risk disease and Afinitor will be used in combination with letrozole. GIST - Pt has tried imatinib or avapritinib, sunitinib, regorafenib, ripretinib and Afinitor will be used in combination with imatinib, sunitinib, or regorafenib. Classical Hodgkin Lympoma - approve. Meningioma - approve. Soft Tissue Sarcoma - PECOma Recurrent Angiomyolipoma, Lumphangioleiomyomatsosis - approve. Thymomas and Thymic Carcinomas - approve if pt has tried chemotherapy. WM/LPL - Approve if pt has not responded to primary therapy (e.g.bortezomib with dexamethasone, bendamustine, rituximab combination therapy, or carfilzomib with rituximab and dexamethasone) or pt has progressive or relapsed disease.

Alunbrig	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Soft Tissue Sarcoma – Inflammatory Myofibroblastic Tumor (IMT)
Exclusion Criteria	
Required Medical Information	mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Metastatic NSCLC - Approve if pt has metastatic anaplastic lymphoma kinase (ALK)-positive NSCLC as detected by an approved test. Soft Tissue Sarcoma – Inflammatory Myofibroblastic Tumor (IMT) - Approve if pt has IMT with ALK translocation.

Brukinsa	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Chronic

	Lymphocytic Leukemia. Marginal Zone Lymphoma. Small Lymphocytic Lymphoma. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma.
Exclusion Criteria	
Required Medical Information	Diagnosis, prior treatments
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Mantle Cell Lymphoma/Chronic Lymphocytic Leukemia/Small Lymphocytic Leukemia - approve if pt has tried at least one prior systemic therapy. Marginal Zone Lymphoma - approve if pt has tried at least one prior systemic therapy and according to the prescriber, the patient has intolerance or contraindication to Imbruvica (ibrutinib capsule or tablet). Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma - Approve.

Calquence	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Marginal Zone Lymphoma. Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma.
Exclusion Criteria	
Required Medical Information	diagnosis, prior treatments
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma - Approve. Mantle Cell Lymphoma - Approve if pt has tried at last one prior therapy. Marginal Zone Lymphoma - approve if pt has tried at least one prior systemic therapy and according to the prescriber, the patient has intolerance or contraindication to Imbruvica (ibrutinib capsule or tablet). Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma - approve if pt has

	tried at least one prior therapy.

Dupixent	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use with another anti-interleukin monoclonal antibody (e.g. Cinqair, Nucala, Fasenra). Concurrent use with Xolair. Eosinophilic esophagitis.
Required Medical Information	Diagnosis, prescriber specialty, other medications tried and length of trials
Age Restrictions	Asthma-12 years of age and older. Atopic Dermatitis-6 years of age and older. Nasal Polyps-18 years of age and older
Prescriber Restrictions	Atopic Dermatitis-Prescribed by or in consultation with an allergist, immunologist or dermatologist. Asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist. Nasal Polyps-prescribed by or in consultation with an allergist, immunologist or otolaryngologist
Coverage Duration	AD Initial-4 months, Cont-1 year, Asthma/Nasal Polyps Initial-6 months, Cont-1 year
Other Criteria	Asthma-Initial-Approve if pt meets the following criteria (i, ii, and iii):i.Pt meets ONE of the following criteria (a or b):a)has a blood eosinophil level of greater than or equal to 150 cells per microliter within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL) therapy or Xolair OR b)has oral corticosteroid-dependent asthma, per the prescriber AND ii.has received combination therapy with BOTH an inhaled corticosteroid (ICS) and at least one additional asthma controller/maintenance medication (NOTE:An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-5 therapy or Xolair used concomitantly with an ICS. Combo ICS and LABA inhalers would fulfill this requirement) AND iii. asthma is uncontrolled or was uncontrolled prior to starting any anti-IL therapy or Xolair as defined by ONE of the following (a, b, c, d or e): a)experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b)experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department visit in the previous year OR c)has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d)has an FEV1/forced vital capacity (FVC)

	less than 0.80 OR e)The patient's asthma worsens upon tapering of oral corticosteroid therapy. Continuation-Approve if pt continues to receive therapy with an inhaled corticosteroid and has responded to Dupixent therapy as determined by the prescribing physician. Atopic Dermatitis-Initial-meets both a and b: a.has used at least one medium or higher potency prescription topical corticosteroid OR has atopic dermatitis affecting ONLY the face, eyes/eyelids, skin folds, and/or genitalia and has tried tacrolimus ointment AND b.Inadequate efficacy was demonstrated with these previously tried topical prescription therapies, according to the prescribing physician.Continuation-Approve if the pt has responded to Dupixent therapy as determined by the prescribing physician. Nasal Polyps-Initial-pt has chronic rhinosinusitis with nasal polyposis as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan AND has has received at least 3 months of therapy with an intranasal corticosteroid and will continue to receive therapy with an intranasal corticosteroid concomitantly with Dupixent AND pt has experienced two or more of the following symptoms for at least 6 months: nasal congestion, nasal obstruction, nasal discharge, and/or reduction/loss of smell AND Pt meets one of the following: pt has received at least one course of treatment with a systemic corticosteroid for 5 days or more within the previous 2 years, pt has a contraindication to systemic corticosteroid therapy, or pt has had prior surgery for nasal polyps. Continuation-approve if the pt continues to receive therapy with an intranasal corticosteroid AND pt has responded to Dupixent therapy as determined by the prescriber.

Epogen and Procrit	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Anemia due to myelodysplastic syndrome (MDS). Anemia Associated with Myelofibrosis.
Exclusion Criteria	Anemia associated with cancer in patinets not receiving myelosuppressive cancer chemotherapy. Anemia associated with AML, CML or other myeloid cancers. Anemia associated with radiotherapy for cancer. Athletic performance enhancement. Anemia due to acute blood loss.
Required Medical Information	Diagnosis, lab values
Age Restrictions	Anemia due to MDS - 18 years or older
Prescriber Restrictions	Anemia due to MDS/Anemia due to Myelofibrosis - prescribed by or in consultation with a hematologist or oncologist.
Coverage	CKD dialysis-3 yrs. CKD/MDS/HIV-1 yr. Chemo-6 months.

Duration	Myelofibrosis-3 mo, cont.-1 yr. Surgery-1 mo
Other Criteria	Anemia due to CKD on dialysis - approve. Anemia due to CKD not on dialysis - For pts 18 years of age or older, must have a hemoglobin less than 10 g/dL (less than 11.5 g/dL if already receiving an erythropoiesis-stimulating agent[ESA]). If less than 18 years of age, must have a hemoglobin equal to or less than 11 g/dL (equal to or less than 12 g/dL if already receiving an ESA). Pt is currently receiving iron therapy OR pt has adequate iron stores according to the prescriber. Anemia due to Chemotherapy - Approve if pt has a hemoglobin less than 10 g/dL (equal to or less than 12 g/dL if already receiving an ESA), is currently recieving myelosuppressive chemotherapy AND pt is currently receiving iron therapy OR pt has adequate iron stores according to the prescriber. Anemia and HIV on Zidovudine - Pt has a hemoglobin less than 10 g/dL (equal to or less than 12 g/dL if already receiving an ESA) OR has a serum erythropoietin level equal to or less than 500 mU/mL, pt is currently recieving zidovudine AND pt is currently receiving iron therapy OR pt has adequate iron stores according to the prescriber. Reduction of Allogenic RBC Transfusions in Pts Undergoing Surgery - Hgb is less than 13 g/dL AND surgery is elective, nonvascular and noncardiac AND pt is not able or willing to donate autologus blood prior to surgery AND pt is currently receiving iron therapy OR pt has adequate iron stores according to the prescriber. Anemia due to MDS - Pt has a hemoglobin less than 10 g/dL (equal to or less than 12 g/dL if already receiving an ESA) OR has a serum erythropoietin level equal to or less than 500 mU/mL AND pt is currently receiving iron therapy OR pt has adequate iron stores according to the prescriber. Anemia due to Myelofibrosis - Pt has a hemoglobin less than 10 g/dL (equal to or less than 12 g/dL if already receiving an ESA) OR has a serum erythropoietin level equal to or less than 500 mU/mL AND pt is currently receiving iron therapy OR pt has adequate iron stores according to the prescriber. For pts already receiving an ESA, the pt has responded according to the prescriber as defined by a hemoglobin greater than 10 g/dL or an increase of greater than 2 g/dL.

Evrysdi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded
Exclusion Criteria	Patient has Complete Paralysis of All Limbs. Patient has Permanent Ventilator Dependence.
Required Medical Information	
Age Restrictions	2 months and older up to 25 years of age (initial)

Prescriber Restrictions	prescribed by or in consultation with a physician who specializes in the management of patients with spinal muscular atrophy and/or neuromuscular disorders
Coverage Duration	4 months
Other Criteria	Spinal Muscular Atrophy (SMA) - Pt has had a genetic test confirming the diagnosis of SMA with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene reported as at least one of the following: homozygous deletion, homozygous mutation, or compound heterozygous mutation [documentation required] AND has two to four survival motor neuron 2 (SMN2) gene copies [documentation required] AND according to the prescriber, the patient has objective signs consistent with spinal muscular atrophy Types 1, 2, or 3 [documentation required] AND for pts currently receiving or who have received prior treatment with Spinraza, the prescriber attests that further therapy with Spinraza will be discontinued AND pt has not received Zolgensma in the past AND females of current reproductive potential must have the prescriber confirm BOTH of the following: pt is not currently pregnant and effective contraception will be utilized during treatment and for 1 month after the last Evrysdi dose AND dosing of Evrysdi meets ONE of the following based on the current (within the past 1 month) kg weight (a, b, or c): a)0.2 mg/kg once daily if the patient is 2 months to less than 2 years of age OR b)0.25 mg/kg once daily for patients greater than 2 years of age who weigh less than 20 kg OR c)5 mg once daily for patients greater than 2 years of age who weigh more than 20 kg. Continuation - must meet initial criteria AND according to the prescriber, the patient has responded to Evrysdi and continues to have benefit from ongoing Evrysdi therapy by the most recent (within the past 4 months) objective measurement and/or assessment tool.

Imbruvica	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. B-Cell Lymphoma. Central Nervous System Lymphoma (Primary). Hairy Cell Leukemia.
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	CLL/MZL/BCL/CNSL/HCL - 18 years or older
Prescriber Restrictions	
Coverage	GVHD - 1 year. All others - 3 years.

Duration	
Other Criteria	Chronic Lymphocytic Leukemia (CLL) - Approve. Graft-Versus-Host Disease, Chronic (GVHD) - Approve if pt has tried at least one conventional systemic treatment for graft-versus-host disease. Mantle Cell Lymphoma - Approve. Marginal Zone Lymphoma (MZL) - Approve if pt tried at least one systemic regimen. Small Lymphocytic Lymphoma - Approve. Waldenström Macroglobulinemia - Approve. B-Cell Lymphoma (BCL) - Approve if pt has tried at least one systemic regimen. Central Nervous System Lymphoma (Primary) (CNSL) - Approve if pt has tried at least one therapy and according to the prescriber, the patient is not a candidate for or is intolerant to high-dose methotrexate. Hairy Cell Leukemia (HCL) - Approve if pt has tried at least two systemic regimens.

Kynmobi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications not otherwise excluded. .
Exclusion Criteria	Concurrent Use with a Serotonin 5-HT3 Antagonist
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Parkinson's Disease - Approve if the patient is diagnosed with advanced Parkinsons disease, is experiencing "off" episodes (such as muscle stiffness, slow movements or difficulty starting movements), is currently receiving carbidopa/levodopa, and has previously tried one other treatment for “off” episodes to which the pt had significant intolerance to or inadequate efficacy from, according to the prescriber.

Nuedexta	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Heroin detoxification. Levodopa-Induced Dyskinesia in Parkinson’s Disease. Neuropathic Pain. Psychosis-Related Aggression. Treatment-Resistant Depression

Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	1 year
Other Criteria	Treatment of Pseudobulbar Affect - Approve if pt has pseudobulbar affect associated with a chronic neurological condition.

Ocaliva	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Alcoholic liver disease. Nonalcoholic Fatty Liver Disease, including Nonalcoholic Fatty liver or Nonalcoholic Steatohepatitis.
Required Medical Information	Diganosis, lab results, prior therapies
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician
Coverage Duration	Initial - 6 months. Continuation - 1 year
Other Criteria	Primary Biliary Cholangitis - Approve if pt has a diagnosis of primary biliary cholangitis as defined by TWO of the following: alkaline phosphatase is elevated above the upper limit of normal as defined by normal laboratory reference values, positive anti-mitochondrial antibodies or other primary biliary cholangitis-specific auto-antibodies including, sp100 or gp210, if anti-mitochondrial antibodies are negative, or histologic evidence of primary biliary cholangitis from a liver biopsy AND pt either has been receiving ursodiol therapy for greater than 1 year and has had an inadequate response or is unable to tolerate ursidiol therapy, according to the prescriber AND pt either does not have cirrhosis or has compensated cirrhosis without evidence of portal hypertension. Continuation - Approve if pt either does not have cirrhosis or has compensated cirrhosis without evidence of portal hypertension AND pt has responded to Ocaliva as determined by the prescriber.

Orkambi

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Cystic Fibrosis heterozygous for the F508del Mutation. Combination use with Kalydeco, Symdeko, or Trikafta.
Required Medical Information	
Age Restrictions	2 years or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of CF.
Coverage Duration	3 years.
Other Criteria	Cystic Firbosis - Approve if pt is homozygous for the F508del mutation in the CFTR gene.

Piqray	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications not otherwise excluded from coverage.
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Breast Cancer - Approve if pt is a postmenopausal female, a male, or a premenopausal female who is receiving ovarian suppression with a gonadotropin-releasing hormone (GnRH) analog or has had surgical bilateral oophorectomy or ovarian irradiation AND has advanced or metastatic hormone receptor (HR)-positive disease, human epidermal growth factor receptor 2 (HER2)-negative disease, and PIK3CA-mutated breast cancer as detected by an approved test AND has progressed on or after at least one prior endocrine-based regimen AND Piqray will be used in combination with fulvestrant injection.

Solaraze

PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Actinic Cheilitis. Disseminated Superficial Actinic Porokeratosis.
Exclusion Criteria	Osteoarthritis
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Actinic Keratoses - Approve. Actinic Cheilitis (Actinic Keratoses of the Lips) - Approve. Disseminated Superficial Actinic Porokeratosis - Approve if pt has treid at least two other therapies used for the management of disseminated superficial actinic porokeratosis. Note: Examples of therapies for management of disseminated superficial actinic porokeratosis include topical 5-fluorouracil (5-FU), imiquimod, topical corticosteroids, topical vitamin D3 analogs, topical or oral retinoids, cryotherapy, photodynamic therapy, and laser.

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	Chondrosarcoma or Chordoma, 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 previously tried imatinib or avapritinib, sunitinib, regorafinib, and ripretinib. Myeloid/Lymphoid Neoplasms with Eosinophilia - approve if tumor has an ABL1 rearrangement.

Stivarga	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications not otherwise excluded. Glioblastoma. Osteosarcoma. Soft Tissue Sarcoma
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies tried, mutations
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years.
Other Criteria	Colon and Rectal Cancer - pt has advanced or metastatic disease AND has been previously treated with a fluoropyrimidine (e.g., capecitabine, 5-fluorouracil [5-FU]) AND oxaliplatin AND irinotecan AND if the pt's tumor or metastases are wild-type RAS (KRAS and/or NRAS negative), then Erbitux (cetuximab injection for intravenous infusion) or Vectibix (panitumumab injection for intravenous infusion) has also been tried. Gastrointestinal Stromal Tumor (GIST) - approve if pt has previously tried sunitinib and either imatinib or avapritinib. Hepatocellular Carcinoma - approve if pt has been previously treated with at least one tyrosine kinase inhibitor (e.g. Nexavar, Lenvima). Glioblastoma - approve if pt has recurrent disease. Osteosarcoma - approve if pt has relapsed/refractory or metastatic disease AND Stivarga is used as subsequent therapy. Soft Tissue Sarcoma - approve if pt has advanced or metastatic disease AND one of the following: Non-adipocytic extremity/body wall, head/neck, or retroperitoneal/intra-abdominal sarcoma OR Pleomorphic rhabdomyosarcoma OR Angiosarcoma OR Solitary fibrous tumor.

Strensiq	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion	

Criteria	
Required Medical Information	Diagnosis, genetic testing results
Age Restrictions	
Prescriber Restrictions	prescribed by or in consultation with a geneticist, endocrinologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of hypophosphatasia or related disorders
Coverage Duration	3 years.
Other Criteria	Hypophosphatasia - Infantile- and Juvenile-Onset - Approve if pt has a diagnosis supported by one of the following: molecular genetic testing documenting tissue non-specific alkaline phosphatase (ALPL) gene mutation, low baseline serum alkaline phosphatase activity, or an elevated level of a tissue non-specific alkaline phosphatase substrate (i.e., serum pyridoxal 5'-phosphate, serum or urinary inorganic pyrophosphate, urinary phosphoethanolamine) AND one of the following: pt currently has a history of clinical manifestations consistent with hypophosphatasia (e.g. skeletal abnormalities, premature tooth loss, muscle weakness, poor feeding, failure to thrive, respiratory problems, vitamin B6-dependent seizures) or pt has a family history (parent or sibling) of hypophosphatasia without current clinical manifestations of hypophosphatasia AND disease onset was before 19 years of age.

Sutent	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Bone Cancer. Meningioma. Myeloid/Lymphoid Neoplasms with Eosinophilia. Soft Tissue Sarcoma. Thymic Carcinoma. Differentiated Thyroid Carcinoma. Medullary Thyroid Carcinoma.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results, previous therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years.
Other Criteria	Gastrointestinal stromal tumors (GIST) - Approve if pt has tried imatinib or avapritinib. Neuroendocrine Tumors of the Pancreas -

	Approve if pt has advanced or metastatic disease. Renal Cell Cancer - Approve if pt has clear cell histology with either a high risk recurrence following nephrectomy and Sutent is being used as adjuvant therapy OR pt has relapsed or advanced disease. Bone Cancer - Approve if pt has recurrent chordoma. Meningioma - Approve if pt has recurrent or progressive disease. Myeloid/Lymphoid Neoplasms with Eosinophilia - Approve if the tumor has an FLT3 rearrangement. Soft Tissue Sarcoma - Approve if the pt has Alveolar Soft Part Sarcoma, Angiosarcoma, or Solitary Fibrous Tumor/Hemangiopericytoma. Thymic Carcinoma - Approve if pt has tried at least one systemic chemotherapy regimen. Thyroid Carcinoma, Differentiated - Approve if pt has differentiated thyroid carcinoma which is refractory to radioactive iodine therapy. Thyroid Carcinoma, Medullary - Approve if pt has tried at least one systemic therapy.

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	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 imatinib or avapritinib, sunitinib, regorafinib, and ripretinib. Myeloid/Lymphoid Neoplasms with Eosinophilia - approve if tumor has an ABL1 rearrangement.

Venclexta

PA Criteria	Criteria Details
Covered Uses	All FDA-approved indications not otherwise excluded. Mantle Cell Lymphoma. Multiple Myeloma.
Exclusion Criteria	
Required Medical Information	Diagnosis, previously tried therapies, mutation status
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years.
Other Criteria	Acute myeloid Leukemia (AML) - Approve if Venclexta is used in combination with either azacitidine, decitabine, or cytarabine. Chronic Lymphocytic Leukemia (CLL) - Approve. Small Lymphocytic Leukemia (SLL) - Approve. Mantle Cell Lymphoma - Approve if pt has tried at least one systemic regimen. Multiple Myeloma - Approve if pt has t (11;14) translocation, has tried at least one systemic therapy for multiple myeloma, and Venclexta is used in combination with dexamethasone.

Votrient	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Bone Cancer. Gastrointestinal Stromal Tumor. Ovarian Cancer. Differentiated Thyroid Carcinoma. Medullary Thyroid Carcinoma. Uterine Sarcoma.
Exclusion Criteria	
Required Medical Information	Diagnosis, previously tried therapies
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years.
Other Criteria	Renal Cell Cancer - Approve if pt has relapsed or advanced disease. Soft Tissue Sarcoma - Approve if pt does not have gastrointestinal stromal tumor, has advanced or metastatic disease, and has one of the following: alveolar soft part sarcoma, angiosarcoma, desmoid tumors (aggressive fibromatosis), pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is

	unresectable or progressive, soft tissue sarcoma of the extremity/superficial trunk or head/neck, including synovial sarcoma, or solitary fibrous tumor/hemangiopericytoma. Bone Cancer - Approve if pt has chondrosarcoma and either has metastatic disease or the prescriber indicates pt has widespread disease. Gastrointestinal Stromal Tumor (GIST) - Approve if pt has tried imatinib or avapritinib, sunitinib, regorafinib, and ripretinib. Ovarian Cancer - Approve if pt has persistent or recurrent disease. Thyroid Carcinoma, Differentiated - Approve if pt has differentiated thyroid carcinoma which is refractory to radioactive iodine therapy. Thyroid Carcinoma, Medullary - Approve if pt has tried at least one systemic therapy. Uterine Sarcoma (e.g., endometrial stromal sarcoma, undifferentiated uterine sarcoma, uterine leiomyosarcomas) - Approve if pt has recurrent, advanced, or metastatic disease.

Xolair	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Atopic Dermatitis. Concurrent use with an interleukin (IL) antagonist monoclonal antibody (eg., Cinqair, Dupixent, or Nucala). Eosinophilic Gastroenteritis, Eosinophilic Esophagitis, or Eosinophilic Colitis. Latex Allergy in Health Care Workers with Occupational Latex Allergy. Peanut and Other Food Allergies.
Required Medical Information	Diagnosis, other medications tried.
Age Restrictions	Asthma - 6 years and older. Urticaria - 12 years and older. Nasal Polyps - 18 years and older.
Prescriber Restrictions	Asthma - prescribed by or in consultation with an allergist, immunologist, or pulmonologist. Chronic Idiopathic Urticaria - prescribed by or in consultation with an allergist, immunologist, or dermatologist. Nasal Polyps - prescribed by or in consultation with an allergist, immunologist, or an otolaryngologist.
Coverage Duration	Initial Asthma/Urticaria - 4 mo. Initial Polyps - 6 mo. Cont therapy for all - 1 year.
Other Criteria	Asthma - approve if pt has baseline immunoglobulin E (IgE) level greater than 30 IU/mL AND a baseline positive skin test or a blood test for allergen-specific IgE for one or more perennial aeroallergens (e.g. house dust mite, animal dander, cockroach, feathers, and mold spores) and/or for one or more seasonal aeroallergens (e.g. grass, pollen, and weeds) AND has received at least 3 consecutive months of combination therapy with BOTH an inhaled corticosteroid (ICS) and at

	least one additional asthma controller/maintenance medication (e.g. inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, theophylline, anti-IL-4/13 [e.g. Dupixent]) AND has asthma that is uncontrolled or was uncontrolled at baseline as defined by ONE of the following: a)Patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year, b)Patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department visit in the previous year, c)Patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted, d)Patient has an FEV1/forced vital capacity (FVC) less than 0.80, e)Patient has asthma that worsens upon tapering of oral corticosteroid therapy. Continuation - approve if pt is concomitantly using an ICS and has responded to therapy as determined by the prescriber. Chronic Idiopathic Urticaria (Chronic Spontaneous Urticaria) - Approve if pt has/had urticaria for greater than 6 weeks (prior to treatment with Xolair), with symptoms present more than 3 days per week despite daily non-sedating H1 antihistamine therapy with doses that have been titrated up to a maximum of four times the standard FDA-approved dose. Continuation - approve if pt has responded to therapy as determined by the prescriber. Nasal Polyps - Approve if pt has chronic rhinosinusitis with nasal polyposis as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan AND has experienced two or more of the following symptoms for at least 6 months: nasal congestion, nasal obstruction, nasal discharge, and/or reduction/loss of smell AND has a baseline immunoglobulin E (IgE) level greater than 30 IU/mL AND pt has received at least 3 months of therapy with an intranasal corticosteroid and will continue to receive therapy with an intranasal corticosteroid concomitantly with Xolair AND pt meets one of the following: Pt has received at least one course of treatment with a systemic corticosteroid for 5 days or more within the previous 2 years, pt has a contraindication to systemic corticosteroid therapy, or pt has had prior surgery for nasal polyps. Continuation - approve if pt has already received at least 6 months of therapy with Xolair and is concomitantly using a nasal corticosteroid and has responded to therapy as determined by the prescriber.

Zydelig	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Marginal Zone Lymphoma.
Exclusion Criteria	
Required Medical	Diagnosis, previously tried therapies

Information	
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years.
Other Criteria	Chronic Lymphocytic Leukemia (CLL) - Approve if pt has tried at least two systemic therapies. Follicular Lymphoma - Approve if pt has tried at least two systemic therapies. Small Lymphocytic Leukemia (SLL) - Approve if pt has tried at least two systemic therapies. Marginal Zone Lymphoma (Marginal Zone Lymphoma includes Gastric MALT Lymphoma, Nongastric MALT Lymphoma, Nodal Marginal Zone Lymphoma, and Splenic Marginal Zone Lymphoma) - Approve if pt has tried at least two systemic therapies.

Zykadia	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Non-Small Cell Lung Cancer with ROS1 Rearrangement. Soft Tissue Sarcoma - Inflammatory Myofibroblastic Tumor (IMT).
Exclusion Criteria	
Required Medical Information	mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years.
Other Criteria	Non-Small Cell Lung Cancer - Apporve if pt has metastatic anaplastic lymphoma kinase (ALK)-positive NSCLC as detected by an approved test. Non-Small Cell Lung Cancer with ROS1 rearrangement - Approve if pt has ROS1 rearrangement-positive NSCLC and is receiving Zykadia as first-line treatment. Soft Tissue Sarcoma – Inflammatory Myofibroblastic Tumor (IMT) - Approve if pt has IMT with anaplastic lymphoma kinase (ALK) translocation.