people powered health plans

Prior Authorization Criteria Updates Effective October 1, 2022

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

On October 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.

Alecensa	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Anaplastic Large Cell Lymphoma. Erdheim-Chester Disease
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC) - Approve if the pt has advanced or metastatic disease and anaplastic lymphoma kinase (ALK)-positive disease detected by an approved test. Anaplastic Large Cell Lymphoma - Approve if pt has anaplastic lymphoma kinase (ALK)-positive disease. Erdheim-Chester Disease - Approve if pt has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease.

Alunbrig	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Erdheim-Chester Disease. Inflammatory Myofibroblastic Tumor (IMT).
Exclusion	

Criteria	
Required Medical Information	mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC) - Approve if pt has advanced or metastatic disease and anaplastic lymphoma kinase (ALK)-positive disease as detected by an approved test. Erdheim-Chester Disease - Approve if pt has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease. Inflammatory Myofibroblastic Tumor (IMT) - Approve if pt has IMT with ALK translocation.

Ayvakit	
PA Criteria	**Criteria Details**
Covered Uses	All FDA approved indications not otherwise excluded from coverage. Myeloid/Lymphoid Neoplasms with Eosinophilia.
Exclusion Criteria	
Required Medical Information	diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Gastrointestinal Stromal Tumor (GIST) - Approve if the tumor is positive for platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation (PDGFRA exon 18 mutation includes PDGFRA D842V mutations) or pt has previously tried imatinib, sunitinib or dasatinib, regorafinib, and ripretinib. Systemic Mastocytosis - approve if pt has a platlet count of greater than 50,000/mcL and has aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm, or mast cell leukemia. Myeloid/Lymphoid Neoplasms - approve if the pt has eosinophilia and the tumor is positive for platelet-derived growth factor receptor alpha (PDGFRA) D842V mutation.

Cabometyx	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Bone Cancer. Endometrial Carcinoma. Gastrointestinal Stromal Tumors. Non-Small Cell Lung Cancer.
Exclusion Criteria	Metastatic Castration-Resistant Prostate Cancer
Required Medical Information	Diagnosis, previous therapies tried, mutation status
Age Restrictions	HCC/RCC/Endometrial carcinoma/GIST/NSCLC - 18 years or older. Thyroid carcinoma - 12 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Hepatocellular Carcinoma (HCC) - Approve if pt has been previously treated with at least one systemic therapy. Renal Cell Carcinoma (RCC) - Approve if pt has relapsed or stage IV disease. Thyroid Carcinoma, Differentiated - Approve if pt has differentiated thyroid carcinoma, is refractory to radioactive iodine therapy, and has Lenvima or Nexavar. Bone Cancer - Approve if pt has tried at least one previous systemic regimen and has Ewing sarcoma or osteosarcoma. Endometrial Carcinoma - Approve if pt has tried one systemic regimen. Gastrointestinal Stromal Tumors (GIST) - Approve if pt has tried imatinib or Ayvakit (avapritinib), Sutent (sunitinib) or Sprycel (dasatinib), Stivarga (regorafinib), and Qinlock (ripretinib) . Non-Small Cell Lung Cancer (NSCLC) - Approve if tumor is positive for RET rearrangements.

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	diagnosis, prior treatments

Information	
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
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.

Caprelsa	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Differentiated Thyroid Carcinoma.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Medullary Thyroid Cancer - approve. Differentiated Thyroid Carcinoma (i.e., papillary, follicular, and Hürthle)- approve if refractory to radioactive iodine therapy.

Cometriq	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Non-Small Cell Lung Cancer. Differentiated Thyroid Carcinoma.
Exclusion Criteria	Metastatic Castration-Resistant Prostate Cancer

Required Medical Information	Diagnosis, mutation results
Age Restrictions	Differentiated Thyroid Carcinoma - 12 years or older. Medullary Thyroid Carinoma/NSCLC - 18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Medullary Thyroid Cancer - Approve. Non-Small Cell Lung Cancer (NSCLC) - approve if pt has RET gene rearrangements. Differentiated Thyroid Carcinoma (i.e., papillary, follicular, and Hürthle)- Approve if refractory to radioactive iodine therapy and pt has tried Lenvima (lenvatinib capsules) or Nexavar (sorafenib tablets).

Copiktra	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Marginal Zone Lymphoma.
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Chronic Lymphocytic Lymphoma - Approve if pt has tried two systemic regimens. Small Lymphocytic Lymphoma - Approve if pt has tried two systemic regimens. Follicular Lymphoma - Approve if pt is currently recieving Copiktra and has tried two systemic regimens. Marginal Zone Lymphoma (includes gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma) - Approve if pt is currently receiving Copiktra and has tried two systemic regimens.

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	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
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 if pt has tried at least one systemic regimen or imbruvica is used in combination with rituximab prior to induction therapy. Marginal Zone Lymphoma (MZL) - Approve if pt tried at least one systemic regimen. Small Lymphocytic Lymphoma - Approve. Waldenström Macroglobulinemia (includes lymphoplasmacytic lymphoma and Bing-Neel syndrome) - 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.

Inlyta	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	ARCC/DTC - 18 years or older
Prescriber	

Restrictions	
Coverage Duration	1 year
Other Criteria	Advanced Renal Cell Carcinoma (ARCC) - Approve. Differentiated Thyroid Cancer (DTC) (examples include papillary, follicular, and Hürthle cell thyroid carcinoma) - Approve if patient is refractory to radioactive iodine therapy. Soft Tissue Sarcoma - Approve if pt has alveolar soft part sarcoma and the medication will be used in combination with Keytruda

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 therapies tried
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
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 advanced disease and pt either using Lenvima in combinatino with Keytruda OR Lenvima is being used with everolimus and pt either has clear cell histology and has tried one antiangiogenic therapy or pt has non-clear cell histology. 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.

Lorbrena	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Erdheim-

	Chester Disease. Inflammatory Myofibroblastic Tumor. Non-Small Cell Lung Cancer - ROS1 Rearrangement-Positive.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results, previous therapies
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer - Anaplastic Lymphoma Kinase (ALK) Positive - Approve if pt has advanced or metastatic disease and ALK-positive disease as detected by an approved test. Erdheim-Chester Disease - Approve if pt has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease. Inflammatory Myofibroblastic Tumor (IMT) - Approve if pt has IMT with anaplastic lymphoma kinase (ALK) translocation. Non-Small Cell Lung Cancer - ROS1 rearrangement-positive - Approve if pt has advanced or metastatic disease and ROS1 rearrangement-positive disease and has tried crizotinib, certinib or entrectinib.

Lumakras	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC) - Approve if pt has KRAS G12C-mutated locally advanced or metastatic NSCLC as determined by an approved test and has been previously treated with at least one systemic regimen.

Nexavar (sorafenib)	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Acute Myeloid Leukemia. Bone Cancer. Gastrointestinal Stromal Tumor. Myeloid/Lymphoid Neoplasms with Eosinophilia. Ovarian, Fallopian Tube, Primary Peritoneal Cancer. Soft Tissue Sarcoma. Thyroid Cancer, Medullary.
Exclusion Criteria	
Required Medical Information	diagnosis, previous therapies tried, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Hepatocellular Cancer - Approve if pt has unresectable or metastatic disease. Renal Cell Cancer - Approve if pt has relapesed or advanced disease AND has clear cell histology AND has tried at least one systemic therapy. Thyroid Carcinoma, Differentiated - Approve if pt has differentiated thyroid carcinoma (papillary, follicular, and Hürthle cell) and the disease is refractory to radioactive iodine therapy. Acute Myeloid Leukemia - Approve if pt has FLT3-ITD mutation-positive disease as detected by an approved test and will use Nexavar in combination with azacitidine or decitabine or pt has had an allogenic stem cell transplant and is in remission. Bone Cancer - Approve if pt has recurrent chordoma OR pt has osteosarcoma and has tried one systemic chemotherapy regimen. Gastrointestinal Stromal Tumor - Approve if pt has previously tried Sutent or Sprycel and Stivarga and Qinlock, and either imatinib or Avyakit. Myeloid/Lymphoid Neoplasms with Eosinophilia - Approve if pt has an FLT3 rearrangement. Ovarian, Fallopian Tube, Primary Peritoneal Cancer - Approve if pt has platinum-resistant disease and Nexavar will be used in combination with topotecan. Soft Tissue Sarcoma - Approve if pt has one of the following diagnoses: angiosarcoma, desmoid tumors, or solitary fibrous Tumor/Hemangiopericytoma. Thyroid Cancer, Medullary - Approve if pt has tried at least one systemic therapy.

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	1 year
Other Criteria	Cystic Fibrosis - 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	1 year
Other Criteria	Breast Cancer - Approve if pt is a postmenopausal female, a male, or a pre/perimenopausal female who is receiving ovarian suppression with a gonadotropin-releasing hormone (GnRH) agonist 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.

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	1 year
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. Pheochromocytoma/Paraganglioma. 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	1 year

Duration	
Other Criteria	Gastrointestinal stromal tumors (GIST) - Approve if pt has tried imatinib or avapritinib or has succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor. 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- Approve if pt has esosinophilia and the tumor has an FLT3 rearrangement. Pheochromocytoma/Paraganglioma - Approve if pt has unresectable or metastatic disease. 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.

Trikafta	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded
Exclusion Criteria	Patients with unknown CFTR gene mutations. Combination therapy with Orkambi, Kalydeco or Symdeko.
Required Medical Information	Diagnosis, specific CFTR gene mutations, concurrent medications
Age Restrictions	6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	1 year
Other Criteria	Cystic Fibrosis (CF) - Patient has at least one copy of one of the following mutations in the cystic fibrosis conductance regulator gene: F508del, 3141del9, E822K, G1069R, L967S, R117L, S912L, 546insCTA, F191V, G1244E, L997F, R117P, S945L, A46D, F311del, G1249R, L1077P, R170H, S977F, A120T, F311L, G1349D, L1324P, R258G, S1159F, A234D, F508C, H139R, L1335P, R334L, S1159P, A349V, F508C,S1251N, H199Y, L1480P, R334Q, S1251N, A455E, H939R, M152V, R347H, S1255P, A554E, F575Y, H1054D, M265R, R347L, T338I, A1006E, F1016S, H1085P, M952I, R347P, T1036N,

	A1067T, F1052V, H1085R, M952T, R352Q, T1053I, D110E, F1074L, H1375P, M1101K, R352W, V201M, D110H, F1099L, I148T, P5L, R553Q, V232D, D192G, G27R, I175V, P67L, R668C, V456A, D443Y, G85E, I336K, P205S, R751L, V456F, D443Y,G576A,R668C, G126D, I502T, P574H, R792G, V562I, D579G, G178E, I601F, Q98R, R933G, V754M, D614G, G178R, I618T, Q237E, R1066H, V1153E, D836Y, G194R, I807M, Q237H, R1070Q, V1240G, D924N, G194V, I980K, Q359R, R1070W, V1293G, D979V, G314E, I1027T, Q1291R, R1162L, W361R, D1152H, G463V, I1139V, R31L, R1283M, W1098C, D1270N, G480C, I1269N, R74Q, R1283S, W1282R, E56K, G551D, I1366N, R74W, S13F, Y109N, E60K, G551S, K1060T, R74W,D1270N, S341P, Y161D, E92K, G576A, L15P, R74W,V201M, S364P, Y161S, E116K, G576A,R668C, L165S, R74W,V201M,D1270N, S492F, Y563N, E193K, G622D, L206W, R75Q, S549N, Y1014C, E403D, G628R, L320V, R117C, S549R, Y1032C, E474K, G970D, L346P, R117G, S589N, E588V, G1061R, L453S, R117H, or S737F.

Truseltiq	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indication not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Cholangiocarcinoma - Approve if pt has unresectable locally advanced or metastatic disease, has fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an approved test, and Truseltiq is used as subsequent therapy.

Venclexta	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Mantle Cell Lymphoma. Multiple Myeloma. Systemic Light Chain Amyloidosis. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma.
Exclusion Criteria	

Required Medical Information	Diagnosis, previously tried therapies, mutation status
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
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. Systemic Light Chain Amyloidosis - Approve if pt has t (11,14) translocation and has tried at least one systemic regimen. Waldenstrom Macroglobulinemia/Lymphoplasmacytic Lymphoma - Approve if pt has tried at least one systemic regimen.

Votrient	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Bone Cancer. Gastrointestinal Stromal Tumor. . Ovarian Cancer, Fallopian Tube, or Primary Peritoneal 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	1 year
Other Criteria	Renal Cell Cancer - Approve if pt has relapsed or advanced disease or has von Hippel-Lindau 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), dermatofibrosarcoma protuberans with fibrosarcomatous transformation, non-adipcytic sarcoma, pleomorphic

	rhabdomyosarcoma, 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 succinate dehydrogenase (SDH)-deficient gastrointestinal stromal tumor or has tried imatinib or avapritinib, sunitinib or dasatinib, regorafinib, and ripretinib. Ovarian Cancer, Fallopian Tube, or Primary Peritoneal 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 or metastatic disease and has tried at least one systemic regimen (doxorubicin, docetaxel, gemcitabine, ifosfamide, dacarbazine, epirubicin, or vinorelbine).

Zydelig	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Marginal Zone Lymphoma.
Exclusion Criteria	
Required Medical Information	Diagnosis, previously tried therapies
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Chronic Lymphocytic Leukemia (CLL) - 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 is currently receiving Zydelig and has tried at least two systemic therapies.

Zykadia	
PA Criteria	**Criteria Details**

Covered Uses	All FDA-approved indications not otherwise excluded. Erdheim-Chester Disease. Inflammatory Myofibroblastic Tumor (IMT). Non-Small Cell Lung Cancer with ROS1 Rearrangement.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer - Apporve if pt has advanced or metastatic disease and anaplastic lymphoma kinase (ALK)-positive disease as detected by an approved test. Erdhem-Chester Disease - Approve if pt has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease. Inflammatory Myofibroblastic Tumor (IMT) - Approve if pt has IMT with anaplastic lymphoma kinase (ALK) translocation. Non-Small Cell Lung Cancer with ROS1 rearrangement - Approve if pt has advanced or metastatic disease and ROS1 rearrangement-positive disease.