people powered health plans

Prior Authorization Criteria Updates Effective November 1, 2021

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

On November 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.

Braftovi	
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	Colon or Rectal Cancer - approve if pt has BRAF V600 mutation positive disease and has previously recived a chemotherapy regimen for colon or rectal cancer and Braftovi will be prescribed as part of a combination regimen for colon or rectal cancer. Melanoma - approve if pt has unresectable, advanced, or metastatic melanoma which is BRAF V600 mutation positive.

Chenodal	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Cerebrotendinous Xanthomatosis.
Exclusion Criteria	Combination Therapy with Cholbam (cholic acid).
Required Medical Information	Diagnosis, previously tried therapies

Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Gallstones - Approve if pt has previously tried or is currently using an ursodiol product.

Cotellic	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Central Nervous System Cancer. Histiocytic Neoplasm.
Exclusion Criteria	
Required Medical Information	Diagnosis. Mutation results. Other therapies tried.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Melanoma - approve if pt has unresectable, advanced, or metastatic melanoma, has BRAF V600 mutation-positive disease, and Cotellic is being prescribed in combination with Zelboraf (vemurafenib). Central Nervous System Cancer - Approve if pt has BRAF V600 mutation-positive disease and the medication is being used for adjuvant treatment of pilocytic astrocytoma, pleomorphic xanthoastrocytoma, or ganglioglioma, or for recurrent disease of low-grade glioma, anaplastic glioma, or glioblastoma, or brain metastases due to melanoma AND the medication is prescribed in combination with Zelboraf (vemurafenib). Histiocytic Neoplasm - Approve if pt has BRAF V600 mutation-positive disease and has Langerhans cell histiocytosis and one of the following: multisystem disease, pulmonary disease, or central nervous system lesions.

Filgrastim	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Acute lymphocytic leukemia (ALL). Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy. Drug induced agranulocytosis or neutropenia. Myelodysplastic syndromes (MDS).

	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Radiation-Induced Neutropenia.
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cancer/AML/MDS/ALL-oncologist or a hematologist. Cancer patients w/ BMT or PBPC -oncologist, hematologist, or a physician who specializes in transplantation. SCN, AA - hematologist. HIV/AIDS neutropenia - infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS. RS - physician who has expertise in treating acute radiation syndrome. RIN - oncologist, radiologist, or radiation oncologist.
Coverage Duration	chemo/SCN/AML-6 mo.HIV/AIDS-4 mo.MDS-3 mo.Drug induce A/N,AA,ALL,BMT-3 mo. PBPC-1mo.Others-12mo.
Other Criteria	Cancer patients receiving chemotherapy - Approve if pt meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, filgrastim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection). Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy - Approve if pt has neutropenia. Radiation-Induced Neutropenia - Approve fi pt is not currently receiving chemotherapy.

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	GVHD - 1 year. All others - 3 years.
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 - 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.

Mekinist	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Biliary Tract Cancer. Central Nervous System Cancer. Histiocytic Neoplasm. Ovarian/Fallopian Tube/Primary Peritoneal Cancer.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results, other therapies tried
Age Restrictions	18 years or older
Prescriber	

Restrictions	
Coverage Duration	3 years
Other Criteria	Melanoma - Approve if pt has unresectable, advanced (including stage III or stage IV disease), or metastatic melanoma and BRAF V600 mutation-positive disease. Non-Small Cell Lung Cancer - Approve if pt has BRAF V600E mutation-positive disease and the medication is prescribed in combination with Tafinlar (dabrafenib). Anaplastic Thyroid Carcinoma - Approve if pt has locally advanced or metastatic anaplastic disease, BRAF V600 mutation-positive disease, and the medication will be taken in combination with Mekinist Tafinlar (dabrafenib), unless intolerant. Biliary Tract Cancer - Approve if pt has tried at least one systemic chemotherapy regimen, has BRAF V600 mutation-positive disease, and the medication will be taken in combination with Tafinlar (dabrafenib). Central Nervous System Cancer - Approve if pt has BRAF V600 mutation-positive disease and the medication is being used for adjuvant treatment of pilocytic astrocytoma, pleomorphic xanthoastrocytoma, or ganglioglioma, or for recurrent disease of low-grade glioma, anaplastic glioma, or glioblastoma, or brain metastases due to melanoma AND the medication is prescribed in combination with Tafinlar (dabrafenib). Histiocytic Neoplasm - Approve if pt has BRAF V600 mutation-positive disease and has Langerhans cell histiocytosis and one of the following: multisystem disease, pulmonary disease, or central nervous system lesions OR pt has Erdheim-Chester disease OR pt has Rosai-Dorfman disease. Ovarian/Fallopian Tube/Primary Peritoneal Cancer - Approve if pt has recurrent disease and the medication is used for low-grade serous carcinoma.

Mektovi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, BRAF V600 mutations
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Melanoma - Approve if pt has unresectable, advanced, or metastatic melanoma which is BRAF V600 mutation-positive, and the medication will be used in combination with Braftovi (encorafenib).

Nucala	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Atopic dermatitis. COPD. Concurrent use with another Anti-Interleukin monoclonal antibody. Concurrent use with Xolair. Eosinophilic esophagitis, eosinophilic gastroenteritis, or eosinophilic colitis.
Required Medical Information	Diagnosis, lab results, previous medication use
Age Restrictions	Asthma - 6 years of age and older. EGPA/NP - 18 years of age and older. Hypereosinophilic syndrome - 12 years of age and older.
Prescriber Restrictions	Asthma - Prescribed by or in consultation with an allergist, immunologist, or pulmonologist. EGPA/Hypereosinophilic Syndrome - Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist. NP - prescribed by or in consultation with an allergist, immunologist, or an otolaryngologist.
Coverage Duration	Asthma/EGPA/NP initial-6mo. Hypereosinophilic syndrome -8mo. Continuation therapy - 1 year.
Other Criteria	Asthma - pt has a blood eosinophil level of greater than 150 cells per mL within the previous 6 weeks or within 6 weeks prior to treatment with any AL-5 therapy AND pt has received at least 3 consecutive months of ICS and at least one additional asthma controller/maintenance medication AND pts asthma is uncontrolled or was uncontrolled prior to starting any anti-interleukin therapy as defined by ONE of the following: two or more exacerbations requiring systemic corticosteroids (CS), one exacerbation which required an ED visit or hospitalization in the previous year, FEV1 of less than 80 percent predicted, or pt has CS dependent asthma. Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome] - pt has has active, non-severe disease and a blood eosinophil level of greater than 150 cells per mL within the previous 6 weeks or within 6 weeks prior to treatment with any AL-5 therapy AND pt has received at least 4 weeks of CS. Hypereosinophilic Syndrome (HS) - pt has had HS for greater than 6 months AND has FIP1L1-PDGFRa-negative disease AND according to the prescriber, the patient does NOT have an identifiable non-hematologic secondary cause of HS AND prior to initiating therapy with any anti-interleukin-5 therapy, the patient has/had a blood eosinophil level of greater than 1,000 cells per mL AND pt has tried at least one other treatment for hypereosinophilic syndrome for a minimum of 4 weeks. Nasal Polyps (NP) - 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. 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 Nucala AND pt has either received at least one course of treatment with a systemic corticosteroid for 5 days or more within the previous 2 years, has a contraindication to systemic corticosteroid therapy, or has had prior surgery for nasal polyps. Continuation (all) - pt has received at least 6 months of Nucala (8mo for HS) and is responding to therapy as determined by prescriber. Continuation (NP) - Pt must also continue to receive therapy with an intranasal corticosteroid.

Odactra	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Concurrent use with subcutaneous allergen immunotherapy (i.e.allergy shots) or other sublingual (SL) allergen immunotherapy.
Required Medical Information	Diagnosis, results of skin test or in vitro test
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with an allergist, immunologist, or an otolaryngologist (ear, nose and throat [ENT]) physician specialist
Coverage Duration	1 year
Other Criteria	House Dust Mite-Induced Allergic Rhinitis - Approve if the diagnosis of house dust mite-induced allergic rhinitis is confirmed by a positive skin test response to house dust mite allergen extracts or a positive in vitro test (i.e., a blood test for allergen-specific IgE antibodies) for house dust mite AND the patient has previously tried an oral antihistamine and a nasal corticosteroid.

Oxervate	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Treatment duration of greater than 16 weeks
Required	Diagnosis

Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or an optometrist.
Coverage Duration	8 weeks
Other Criteria	Neurotrophic keratitis - Initial - Approve. Continuation - Approve if pt has previously received 8 weeks or less of treatment per affected eye(s) and pt has a recurrence of neurotrophic keratitis.

Somavert	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	Treatment of Excess Growth Hormone Associated with McCune-Albright Syndrome (MAS)
Required Medical Information	Diagnosis, previous therapy, concomitant therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	1 year
Other Criteria	Acromegaly - approve if pt meets ONE of the following: has had an inadequate response to surgery and/or radiotherapy, is NOT an appropriate candidate for surgery and/or radiotherapy, or is experiencing negative effects due to tumor size (e.g., optic nerve compression) AND patient has a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory.

Tafinlar	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Biliary Tract Cancer. Central Nervous System Cancer. Histiocytic Neoplasm. Differentiated Thyroid Carcinoma.
Exclusion Criteria	
Required	Diagonsis, mutation results, other therapies tried

Medical Information	
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years.
Other Criteria	Melanoma - Approve if pt has unresectable, advanced (including stage III or stage IV disease), or metastatic melanoma and BRAF V600 mutation-positive disease. Non-Small Cell Lung Cancer - Approve if pt has BRAF V600E mutation-positive disease. Anaplastic Thyroid Carcinoma - Approve if pt has locally advanced or metastatic anaplastic disease, BRAF V600 mutation-positive disease, and the medication will be taken in combination with Mekinist (trametinib), unless intolerant. Biliary Tract Cancer - Approve if pt has tried at least one systemic chemotherapy regimen, has BRAF V600 mutation-positive disease, and the medication will be taken in combination with Mekinist (trametinib). Central Nervous System Cancer - Approve if pt has BRAF V600 mutation-positive disease and the medication is being used for adjuvant treatment of pilocytic astrocytoma, pleomorphic xanthoastrocytoma, or ganglioglioma, or for recurrent disease of low-grade glioma, anaplastic glioma, or glioblastoma, or brain metastases due to melanoma AND the medication is prescribed in combination with Mekinist (trametinib). Histiocytic Neoplasm - Approve if pt has BRAF V600 mutation-positive disease and has Langerhans cell histiocytosis and one of the following: multisystem disease, pulmonary disease, or central nervous system lesions OR pt has Erdheim-Chester disease. Differentiated Thyroid Carcinoma - Approve if pt has differentiated thyroid carcinoma that is refractory to radioactive iodine therapy and is BRAF mutation-positive.

Turalio	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Histiocytic Neoplasms.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage	3 years

Duration	
Other Criteria	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis) - Approve if the tumor is not amenable to improvement with surgery, according to the prescriber. Histiocytic Neoplasms - Approve if pt has a colony stimulating factor 1 receptor (CSF1R) mutation and has one of the following conditions: Langerhans cell histiocytosis, Erdheim-Chester disease, or Rosai-Dorfman disease.

Zelboraf	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Central Nervous System Cancer. Hairy Cell Leukemia. Histiocytic Neoplasm. Non-Small Cell Lung Cancer. Differentiated Thyroid Carcinoma.
Exclusion Criteria	
Required Medical Information	Diagnosis. Mutation results. Other therapies tried.
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Erdheim-Chester Disease - Approve if pt has BRAF V600 mutation-positive disease. Melanoma - Approve if pt has unresectable, advanced, or metastatic melanoma and BRAF V600 mutation-positive disease. Central Nervous System Cancer - Approve if pt has BRAF V600 mutation-positive disease and the medication is being used for adjuvant treatment of pilocytic astrocytoma, pleomorphic xanthoastrocytoma, or ganglioglioma, or for recurrent disease of low-grade glioma, anaplastic glioma, or glioblastoma, or brain metastases due to melanoma AND the medication is prescribed in combination with Cotellic (cobimetinib). Hairy Cell Leukemia - Approve if pt has tried at least one other systemic therapy for hairy cell leukemia. Histiocytic Neoplasm - Approve if pt has BRAF V600 mutation-positive disease and has Langerhans cell histiocytosis and one of the following: multisystem disease, pulmonary disease, or central nervous system lesions. Non-Small Cell Lung Cancer - Approve if pt has BRAF V600E mutation-positive disease. Differentiated Thyroid Carcinoma - Approve if pt has differentiated thyroid carcinoma that is refractory to radioactive iodine therapy and is BRAF mutation-positive.