people powered health plans

Prior Authorization Criteria Updates Effective November 1, 2022

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

On November 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.

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	1 year
Other Criteria	Colon or Rectal Cancer - approve if pt has BRAF V600E mutation positive disease and has previously received 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	CX - prescribed by or in consultation with a metabolic specialist who treats patients with CX
Coverage Duration	1 year
Other Criteria	Gallstones - Approve if pt has previously tried or is currently using an ursodiol product. Cerebrotendinous Xanthomatosis (CX)- Approve.

Inqovi	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Chronic Myelomonocytic Leukemia - Approve. Myelodysplastic Syndromes - Approve.

Kadcyla	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Non-Small Cell Lung Cancer. Salivary Gland Tumor.
Exclusion Criteria	
Required Medical Information	diagnosis, genetic results
Age Restrictions	18 years or older
Prescriber Restrictions	prescribed by or in consultation with an oncologist

Coverage Duration	1 year
Other Criteria	Breast Cancer - approve if HER2-positive AND cancer is recurrent or metastatic OR Kadcyla will be used as adjuvant therapy. Non-Small Cell Lung Cancer - approve if pt has metastatic disease and is HER2-positive. Salivary Gland Tumor - approve if pt has recurrent, unresectable, or metastatic disease and is HER2-positive.

Tafinlar	
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, or Primary Peritoneal Cancer. Differentiated Thyroid Carcinoma.
Exclusion Criteria	Colon or Rectal Cancer
Required Medical Information	Diagnosis, mutation results, other therapies tried
Age Restrictions	6 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Pt. must weigh at least 26kg. Melanoma - Approve if pt has unresectable, advanced (including stage III or stage IV disease), or metastatic melanoma and BRAF V600 mutation-positive disease. Metastatic or Solid Tumors - Approve if pt has BRAF V600 mutation-positive disease and the medication will be taken in combination with Mekinist (trametinib) and pt has no satisfactory alternative treatment options. Non-Small Cell Lung Cancer (NSCLC) - Approve if pt has BRAF V600E mutation-positive disease. Anaplastic Thyroid Carcinoma (ATC) - 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 (BTC) - 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 (CNSC) - 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 or progressive disease of glioma, Isocitrate dehydrogenase-2 (IDH2)-mutant astrocytoma, or oligodendroglioma, or glioblastoma, or brain metastases due to melanoma AND the medication is prescribed in combination with Mekinist (trametinib).

	Histiocytic Neoplasm (HN) - 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. Ovarian FallopianTube or Primary Peritoneal Cancer - pt has recurrent disease and has BRAF V600 mutation-positive diease and the medicaiton will be taken in combination with Mekinist (trametinib). Differentiated Thyroid Carcinoma (DTC) - 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 Duration	1 year
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.

Vonjo	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	diagnosis, lab results
Age Restrictions	18 years or older
Prescriber	

Restrictions	
Coverage Duration	1 year
Other Criteria	Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF - Approve if pt has a platelet count of less than 50,000/mcL AND intermediate or high risk disease and is not a candidate for transplant or lower-risk disease and has tried at least one prior therapy (examples: Jakafi, Pegasys, or hydroxyurea) OR pt has a platelet count of 50,000/mcL or more and high risk disease, is not a candidate for transplant and has tired Jakafi or Inrebic.

Xalkori	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded. Histiocytic Neoplasms. NSCLC with MET Mutation.
Exclusion Criteria	
Required Medical Information	Diagnosis, mutation results
Age Restrictions	NSCLC, HN - 18 years or older. Anaplastic Large Cell Lymphoma - 1 year or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC) Anaplastic Lymphoma Kinase (ALK)-positive - Approve if pt has advanced or metastatic disease and ALK positive disease as detected by an approved test. Non-Small Cell Lung Cancer (NSCLC) with ROS1 Rearrangement - approve if pt has advanced or metastatic disease and ROS1 rearragement has been detected by an approved test. Anaplastic Large Cell Lymphoma - Approve if pt has ALK-positive disease and pt has relapsed or refractory disease. Histiocytic Neoplasms - Approve if pt has ALK-positive disease and pt has one of the following: Langerhans cell histiocytosis, Erdheim-Chester disease, or Rosai-Dorfman disease. Non-Small Cell Lung Cancer (NSCLC) with MET Mutation - Approve if pt has high level MET amplification or MET exon 14 skipping mutation. Inflammatory Myofibroblastic Tumor (IMT) with ALK Translocation - Approve.

Xuriden	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis, lab results
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a metabolic specialist, geneticist or physician specializing in the condition being treated
Coverage Duration	1 year
Other Criteria	Hereditary orotic aciduria (Orotic aciduria Type 1) - Approve if the patient has molecular genetic testing confirming biallelic pathogenic mutations in the UMPS gene or clinical diagnosis supported by all of the following; at least one clinical manifestation consistent with orotic aciduria type 1 and first degree family relative (i.e., parent or sibling) with hereditary orotic aciduria and urinary orotic acid level above the normal reference range for the reporting laboratory.

Zolinza	
PA Criteria	**Criteria Details**
Covered Uses	All FDA-approved indications not otherwise excluded.
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Cutaneous T-Cell Lymphoma including Mycosis Fungoides/Sezary Syndrome- Approve