

PART B PRIOR AUTHORIZATION CRITERIA FOR APPROVAL

Uplizna will be approved when ALL of the following are met:

1. The requested medication is being used for ONE of the following:
 - A. An FDA approved indication
 - OR**
 - B. An indication in CMS approved compendia
- AND**
2. The patient does NOT have any FDA labeled contraindications to the requested medication
- AND**
3. The requested quantity (dose) is within FDA labeled dosing or supported in compendia for the requested indication

Length of Approval: up to 12 months

NOTES:

- Length of approval may be shorter due to provider network participation status.
- LCD/NCD criteria review completed, if applicable, in addition to the Plan's Medicare Part B criteria.