Louisiana Medicaid
Remibrutinib (Rhapsido®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for remibrutinib (Rhapsido®).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of chronic spontaneous urticaria; **AND**
- The medication is prescribed by, or the request states that this medication is being prescribed in consultation with, a dermatologist, immunologist, or allergist; **AND**
- The recipient has been adherent to H1 antihistamine therapy for a minimum of 4 weeks but is still symptomatic. [Each medication and date range of treatment must be **stated on the request**. Adherence to drug therapy will be validated through claims data review].

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy.

Duration of approval for continuation of therapy: 12 months

Reference

Rhapsido (remibrutinib) [package insert]. East Hanover, NJ: Novartis Pharmaceuticals Corporation; September 2025. https://www.novartis.com/us-en/sites/novartis_us/files/rhapsido.pdf

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