Field Name	Field Description
Prior Authorization Group Description	**Treatments for Plasminogen Deficiency Type 1 (PLD1)**
Drugs	Ryplazim (human plasma-derived plasminogen)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), and the Drug Package Insert (PPI).
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	N/A
Prescriber Restrictions	Prescriber must be a hematologist, medical geneticist, or other specialist in the treatment of rare blood or genetic disorders
Coverage Duration	If all of the criteria are met, the initial request will be approved for 12 weeks. Reauthorization requests will be approved for 12 weeks if the member has not had a documented positive response to therapy and for 12 months if the member has had a documented positive response to therapy. ~~If the conditions are not met, the request will be sent to a Medical Director/clinical reviewer for medical necessity review.~~
Other Criteria	****Drug is being requested through the member's medical benefit**** Initial Authorization • Member must have a diagnosis of PLD1 (i.e. hypoplasminogenemia) • Member must have a documented history of lesions or other symptoms consistent with the diagnosis (e.g. ligneous conjunctivitis, oral, respiratory, gastrointestinal, urogenital, integumentary, or central nervous system manifestations) • Member must have baseline plasminogen activity levels ≤ 45% o If the member received plasminogen supplementation with fresh frozen plasma, prescriber attests that a 7-day washout period was performed before obtaining baseline plasminogen activity levels. • The request is for an FDA approved dose Reauthorization • ONE of the following is true: o Member has a documented positive response to therapy (e.g. reduction in number or size of lesions, no new or recurring lesions) o Member has not had a documented positive response to therapy and ONE of the following:

Revision/Review Date ~~5/2022~~ **4/2023**	▪ If confirmed plasminogen activity levels are ≥ 10% above baseline, then appropriate dosing frequency adjustments must be made. ▪ If confirmed plasminogen activity levels are < 10% above baseline, then appropriate dosing frequency adjustments must be made AND the prescriber must provide a medical justification as to why therapy should be continued. • The request is for an FDA approved dose **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**