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)**

Revision/Review Date 5/2022	o **Member has not had a documented positive response to therapy and ONE of the following:** ▪ **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.**