HealthPartners

Mitapivat (Pyrukynd®)

Coverage Criteria:

Initial Authorization Criteria:

Pyrukynd is reserved for:

1. Patient is ≥18 years of age; and,
2. Patient has a diagnosis of hemolytic anemia; and
3. Patient has pyruvate kinase (PK) deficiency; and
4. Pyrukynd is prescribed within the FDA-approved dosing regimen.

Renewal Criteria:

1. Patient continues to meet initial authorization criteria; and,
2. Patient has been seen and evaluated by provider in the past 12 months; and,
3. Patient has had a clinically meaningful response to therapy as defined by hemoglobin and hemolysis laboratory results and transfusion requirements; and,
4. Prescribed within the FDA-approved dosing regimen.

Coverage Duration:

Initial authorization will be provided for 6 months.
Re-authorizations will be provided for 12 months.

Other Criteria:

Quantity Limit of 56 tablets per 28 days

P&T Date: 5/9/2022
Effective Date: 7/1/2022