UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 2393-1
Program	Prior Authorization/Medical Necessity
Medication	Wayrilz™ (rilzabrutinib)
P&T Approval Date	2/2026
Effective Date	5/1/2026

1. Background:

Wayrilz (rilzabrutinib)is a kinase inhibitor indicated for the treatment of adult patients with persistent or chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Wayrilz** will be approved based on **all** of the following criteria:

   a. Diagnosis of persistent or chronic immune thrombocytopenia (ITP)

   -AND-

   b. **One** of the following:

      (1) Patient has had a prior splenectomy

      -OR-

      (2) History of failure/inadequate response, contraindication, or intolerance to **one** of the following (document drug, date, and duration of trial):

         (a) Corticosteroids (e.g., prednisone, methylprednisolone)
         (b) Immunoglobulins

   -AND-

   c. History of failure/inadequate response, contraindication, or intolerance, to **two** of the following (document drug, date, and duration of trial):

      (1) Eltrombopag (e.g. Alvaiz, generic Promacta)
      (2) Doptelet (avatrombopag)
      (3) Tavalisse (fostamatinib)

   -AND-

   d. Platelet count remains less than 30,000/mcL despite previous treatment

© 2026 UnitedHealthcare Services Inc.

-AND-

e. Prescribed by or in consultation with a hematologist/oncologist

Authorization will be issued for 12 months.

B. <u>Reauthorization</u>

1. **Wayrilz** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Wayrilz therapy (e.g. an increase in platelet count to a level sufficient to avoid clinically important bleeding)

Authorization will be issued for 12 months.

[a]State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Wayrilz [Package Insert]. Cambridge, MA: Genzyme Corporation; August 2025.
2. Neunert C,et. al. American Society of Hematology 2019 guidelines for immune thrombocytopenia. Blood Adv. 2019 Dec 10;3(23):3829-3866.

Program	Prior Authorization/Medical Necessity - Wayrilz (rilzabrutinib)
Change Control	
2/2026	New program.

© 2026 UnitedHealthcare Services Inc.