STATE OF WEST VIRGINIA
DEPARTMENT OF HUMAN SERVICES
BUREAU FOR MEDICAL SERVICES

Alex J. Mayer, PhD, MS, PMP
Cabinet Secretary

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Commissioner

Office of Pharmacy Services
Prior Authorization Criteria
Rhapsido® (remibrutinib)
Effective 2/25/2026

Prior Authorization Request Form

RHAPSIDO® is a kinase inhibitor indicated for the treatment of chronic spontaneous urticaria (CSU) in adult patients who remain symptomatic despite H1 antihistamine treatment.

CRITERIA FOR APPROVAL:

1. Must be prescribed by or in consultation with an M.D./D.O. or specialty trained prescriber with a clinical specialty/certification/degree in allergy, immunology or dermatology; **AND**

2. Documented diagnosis of chronic spontaneous urticaria (CSU) with presence of itch and hives for ≥6 consecutive weeks; **AND**

3. The patient must be within the age range as recommended by the FDA label and indication; **AND**

4. The patient must have documented failure of at least 30 days of therapy with a prescribed 2nd-generation H1 antihistamine dosed at 4 times the usual recommended dose, as verified by pharmacy claims data.

Approval Duration: Initial approval will be for 3 months.

Criteria for Reauthorization:

1. Demonstrate continued documented compliance; **AND**

2. Documentation of improvement in symptoms is provided.

Continuation of therapy will be granted for 12 months.