

SENTARA COMMUNITY PLAN (MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-305-2331. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is not complete, correct, or legible, authorization can be delayed.

Drug Requested: Nucala[®] SQ (mepolizumab) Injection (J2182) (Medical)
{Severe Eosinophilic Asthma (SEA)}

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____
Member Sentara #: _____ Date of Birth: _____
Prescriber Name: _____
Prescriber Signature: _____ Date: _____
Office Contact Name: _____
Phone Number: _____ Fax Number: _____
DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____
Dosing Schedule: _____ Length of Therapy: _____
Diagnosis: _____ ICD Code, if applicable: _____
Weight: _____ Date: _____

☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Recommended Dosage for Severe Asthma:

- Pediatric Patients aged 6 – 11 years: 40 mg lyophilized powder, single-dose vial, every 4 weeks, under the guidance of a healthcare provider
- Adults and adolescents aged 12 years and older: 100 mg lyophilized powder, single-dose vial, every 4 weeks

*Sentara Health Plans considers the use of concomitant therapy with Cinqair[®], Dupixent[®], Fasenra[®], Nucala[®], Tezspire[™] and Xolair[®] to be experimental and investigational. Safety and efficacy of these combinations have **NOT** been established and will **NOT** be permitted. In the event a member has an active Cinqair[®], Dupixent[®], Fasenra[®], Tezspire[™] or Xolair[®] authorization on file, all subsequent requests for Nucala[®] will **NOT** be approved.

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. (Trials will be verified using pharmacy claims and/or submitted chart notes.)

Initial Authorization: 12 months

- ☐ Prescribed by or in consultation with an allergist, immunologist or pulmonologist
- ☐ Member is 6 years of age or older
- ☐ Has the member been approved for Nucala[®] previously through the Sentara Health Plans pharmacy department?
 - ☐ Yes ☐ No
- ☐ Member has been diagnosed with severe eosinophilic phenotype defined by a baseline (pre-Nucala[®] treatment) peripheral blood eosinophil level ≥ 150 cells/microliter
- ☐ Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications and must be compliant on therapy **for at least 90 consecutive days** within a year of request:
 - ☐ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) **AND** an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)
 - ☐ One maximally dosed combination ICS/LABA product (e.g., Advair[®] (fluticasone propionate/salmeterol), Dulera[®] (mometasone/formoterol), Symbicort[®] (budesonide/formoterol))
- ☐ Member has experienced **ONE** of the following (check box that applies):
 - ☐ More than > 2 exacerbations requiring additional medical treatment (e.g., an increase in oral corticosteroid dose, emergency department, urgent care visits or hospitalizations) within the past 12 months
 - ☐ Any prior intubation for an asthma exacerbation
- ☐ Member has a baseline forced expiratory volume (FEV1) < 80% predicted normal (< 90% for members 6-17 years old) submitted within year of request
- ☐ Provider must submit member blood eosinophil count after a trial and failure of at least 90 consecutive days of therapy with high dose inhaled corticosteroids **AND** long-acting inhaled beta-2 agonist. A failure of these medications is defined as a blood count > 150 cells/microliter (**submit labs collected within the past 12 months**)

Eosinophil count: _____ Date: _____

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Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member has experienced a sustained positive clinical response to Nucala® therapy as demonstrated by at least **ONE** of the following (**check all that apply; chart notes must be submitted**):
 - ☐ Increase in percent predicted Forced Expiratory Volume (FEV1) from baseline (pre-treatment)
 - ☐ Reduction in the dose of inhaled corticosteroids required to control asthma
 - ☐ Reduction in the use of oral corticosteroids to treat/prevent exacerbation
 - ☐ Reduction in asthma symptoms such as chest tightness, coughing, shortness of breath or nocturnal awakenings
- ☐ Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications:
 - ☐ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) **AND** an additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)
 - ☐ One maximally dosed combination ICS/LABA product (e.g., Advair® (fluticasone propionate/salmeterol), Dulera® (mometasone/formoterol), Symbicort® (budesonide/formoterol))

Medication being provided by (check applicable box(es) below):

☐ **Location/site of drug administration:** _____

NPI or DEA # of administering location: _____

OR

☐ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****