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: Niktimvo™ (axatilimab-csfr) **(J9038) (Medical)**

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

☐ 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.

Dosing Limits

A. Quantity Limit (max daily dose) [NDC Unit]:

- 9 mg/0.18 mL single dose vial: 2 vials every 2 weeks
- 22 mg/0.44 mL single dose vial: 1 vial every 2 weeks

B. Max Units (per dose and over time) [HCPCS Unit]:

- 35 mg once every 2 weeks
- 360 billable units every 2 weeks
- 9 mg/0.18 mL single dose vial: 1 vial = 90 billable units; 2 vials = 180 billable units
- 22 mg/0.44 mL single dose vial: 1 vial = 220 billable units

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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.

Initial Authorization: 6 months

- ❑ Member weighs at least 40kg
- ❑ Member has recurrent or refractory chronic graft versus host disease (cGVHD)
- ❑ Used as a single agent or in conjunction with systemic steroids, calcineurin inhibitors (e.g., cyclosporin, etc.) or mTOR inhibitors (e.g., sirolimus, everolimus, etc.)
- ❑ Member is post-allogeneic stem cell transplant
- ❑ Member has failed **two or more** previous lines of systemic therapy for the treatment of cGVHD (e.g., corticosteroids, immunosuppressants)

Reauthorization: 6 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 continues to meet the relevant criteria identified in the initial criteria
- ❑ Member has an absence of unacceptable toxicity from the drug (e.g., severe infusion related reactions, periorbital edema)
- ❑ Member is being continuously monitored for a beneficial response to therapy

Medication being provided by: Please check applicable box 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.**

***Approved by Pharmacy and Therapeutics Committee**: 3/27/2025
REVISED/UPDATED/REFORMATTED: ~~4/15//2025;~~ **6/10/2026**