SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Aqneursa™ (levacetylleucine)

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:** _____

Recommended Dosing:

Patient Body Weight	Morning Dose	Afternoon Dose	Evening Dose	Required Cartons per Fill
15 to <25 kg	1 g	No Dose	1 g	2 cartons per 28 days
25 to <35 kg	1 g	1 g	1 g	3 cartons per 28 days
35 kg or more	2 g	1 g	1 g	4 cartons per 28 days

Quantity Limits: 112 packets (4 cartons) per 28 days

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: 12 months

(Continued on next page)

- ❑ Member is ≥ 4 years of age
- ❑ Member weighs ≥ 15 kg
- ❑ Prescribed by or in consultation with a geneticist, endocrinologist, metabolic disorder subspecialist, neurologist, or a physician who specializes in the treatment of Niemann-Pick disease type C or related disorders
- ❑ Member has a confirmed diagnosis of Niemann-Pick disease type C (NPC) as established by a genetic test showing **ONE** of the following **(submit documentation)**:
  - ❑ Biallelic pathogenic variants in either the NPC1 gene or NPC2 gene
  - ❑ Mutations in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane-triol level (>2 times the upper limit of normal)
- ❑ Member has at least **ONE** neurological symptom(s) of Niemann-Pick disease type C (e.g., loss of motor function, swallowing, and speech and cognitive impairment) **(submit documentation)**
- ❑ Member can walk independently or with assistance
- ❑ Provider must submit a baseline assessment scale documenting current NPC neurologic symptom(s) **(submit documentation)**
- ❑ Requested medication will **NOT** be used in combination with Miplyffa™ (arimoclomol) for the treatment of neurological manifestations of Niemann-Pick disease type C

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 continues to meet **ALL** initial authorization criteria
- ❑ Member has derived benefit from treatment defined as disease stabilization, slowed progression, or improvement, according to the prescriber

Medication being provided by Specialty Pharmacy – Proprium Rx

*****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: 1/23/2025**
REVISED/UPDATED/REFORMATTED: 2/18/2025