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**.

IV Eculizumab Products- Neuromyelitis Optica Spectrum Disorder (NMOSD)
(MEDICAL)

Drug Requested: select one drug below:

❑ **Epysqli®** (eculizumab-aagh) **Q5151**	❑ **Soliris®** (eculizumab) **J1299**

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.

Recommended Dosage:

Maximum Quantity Limit – 4 vials every 14 days; one 300 mg vial (30 mL) = 150 billable units [1 billable unit per 2 mg]

- IV Induction – 900 mg weekly for 4 doses; Maintenance – 1200 mg at week 5, then 1200 mg every 2 weeks thereafter

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- Dosage adjustment for members receiving plasmapheresis or plasma exchange:
  - If most recent dose was ≥ 600 mg, administer 600 mg within 60 minutes after each plasmapheresis or plasma exchange
  - If most recent dose was 300 mg, administer 300 mg within 60 minutes after each plasmapheresis or plasma exchange
- Dose adjustment for members receiving fresh frozen plasma infusion:
  - If most recent dose was ≥ 300 mg, administer 300 mg within 60 minutes prior to each infusion of fresh frozen plasma

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 must be 18 years of age or older
- ❑ Provider must submit medical records (e.g., chart notes, laboratory values, etc.) to support a diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) confirmed by **ALL** the following:
  - ❑ Past medical history of **ONE** of the following:
    - ❑ Optic neuritis
    - ❑ Acute myelitis
    - ❑ Area postrema syndrome; episode of otherwise unexplained hiccups or nausea and vomiting
    - ❑ Acute brainstem syndrome
    - ❑ Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
    - ❑ Symptomatic cerebral syndrome with NMOSD-typical brain lesions
  - ❑ Positive serologic test for anti-aquaporin-4 immunoglobulin (AQP4-IgG) antibodies **(must submit lab results)**
- ❑ Diagnosis of multiple sclerosis or other diagnoses have been ruled out
- ❑ Member is free of *Neisseria meningitidis* infection
- ❑ Member will **NOT** be using the requested agent in combination with Ultomiris (ravulizumab-cwvz), Bkemv (eculizumab-aeeb), or Epysqli (eculizumab-aagh)
- ❑ Member will **NOT** be using the requested agent in combination with Enspryng (satralizumab-mwge), Rituximab, or Uplizna (inebilizumab-cdon)

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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 continues to meet the relevant criteria identified in the initial criteria
- ❑ Member has absence of unacceptable toxicity from the drug (e.g., serious meningococcal infections (septicemia and/or meningitis), infusion reactions, serious infections)
- ❑ Member is being continuously monitored for a beneficial response to therapy

EXCLUSIONS: Therapy will **NOT** be approved if member has history of any of the following:

- Unresolved meningococcal disease

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____
  OR
- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan'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:** ~~2/15/2018; 8/15/2019;~~ **5/23/2024**
REVISED/UPDATED/REFORMATTED~~: 10/30/2019; 4/1/2021; 6/30/2021; 6/7/2024; 4/24/2025; 5/8/2025, 8/11/2026,~~ **9/17/2026**