SENTARA HEALTH PLANS

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 1-844-668-1550**. 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**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Nucala® (mepolizumab) **(J2182) (Medical)**
Chronic rhinosinusitis with nasal polyps (CRSwNP)

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:** _____

Quantity Limit: 100 mg per 28 days

***Sentara considers the use of concomitant therapy with Cinqair®, Nucala®, Dupixent®, Fasenra®, 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®, and/or Xolair® authorization on file, any subsequent requests for Nucala® will NOT be approved.**

☐ 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.

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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.

❑ DIAGNOSIS: Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with an allergist, immunologist or otolaryngologist
- ❑ Member is 18 years of age or older
- ❑ Member has a **diagnosis of CRSwNP** confirmed by the American Academy of Otolaryngology-Head and Neck Surgery Clinical Practice Guideline (Update): Adult Sinusitis (AAO-HNSF 2015)/American Academy of Allergy Asthma & Immunology (AAAAI) with **ONE** of the following clinical procedures:
  - ❑ Anterior rhinoscopy
  - ❑ Nasal endoscopy
  - ❑ Computed tomography (CT)
- ❑ Documented diagnosis of chronic rhinosinusitis defined by at least 12 weeks of the following **(chart notes must be submitted)**:
  - ❑ Mucosal inflammation **AND** at least **TWO** of the following:
    - ❑ Decreased sense of smell
    - ❑ Facial pressure, pain, fullness
    - ❑ Mucopurulent drainage
    - ❑ Nasal obstruction
- ❑ Member is currently being treated with medications in at least **TWO** of the following categories 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 **(chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes)**:
  - ❑ Nasal saline irrigation
  - ❑ Intranasal corticosteroids (e.g., fluticasone, budesonide, triamcinolone)
  - ❑ Leukotriene receptor antagonists (e.g., montelukast, zafirlukast, zileuton)
- ❑ Member is refractory, ineligible or intolerant to **ONE** of the following:
  - ❑ Systemic corticosteroids
  - ❑ Sino-nasal surgery
- ❑ Member is requesting Nucala® (mepolizumab) as add-on therapy to maintenance intranasal corticosteroids

Reauthorization Approval - 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.

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- ❑ Member has experienced a positive clinical response to Nucala® therapy (e.g., reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, improved sense of smell) **(chart notes must be submitted)**
- ❑ Decreased utilization of oral corticosteroids **(verified by pharmacy paid claims)**
- ❑ Member has been compliant on Nucala® therapy and continues to receive therapy with an intranasal corticosteroid **(verified by pharmacy paid claims)**

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

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

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 Therapeutic Committee:** 11/1/2021
REVISED/UPDATED: ~~12/13/2021;~~ **12/23/2021**