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: Nucala® SQ (mepolizumab) **Injection (Pharmacy) (Non-Preferred)**
Chronic Obstructive Pulmonary Disease* (COPD)

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 Dosage for COPD*:

- Adults: 100 mg/mL SubQ, single-dose prefilled auto-injector or single dose prefilled syringe, once every 4 weeks

Quantity Limit: 100 mg per 28 days

***The Health Plan considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, 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.

Initial Authorization: 6 months

1. Has the member been approved for Nucala® previously through the Sentara medical department?
   ❑ Yes ❑ No
2. Is the member 18 years of age or older?
   ❑ Yes ❑ No
3. Does the member have a diagnosis of COPD with moderate to very severe airflow limitation, as defined by FEV1/FVC ratio < 0.7 and post-bronchodilator FEV1 of 20% to 80% predicted?
   ❑ Yes ❑ No
4. Does the member have a peripheral blood eosinophil count ≥ 150 cells/µL at screening or ≥ 300 cells/µL in the year prior?
   ❑ Yes ❑ No
5. Will therapy be used for add-on maintenance treatment in members regularly receiving background triple inhaled therapies (i.e. ICS, long-acting beta agonist, and long-acting muscarinic antagonist) unless otherwise contraindicated?
   ❑ Yes ❑ No
6. Has the member had at least 2 moderate (requiring treatment with oral/systemic corticosteroids and/or antibiotics) or 1 severe (requiring inpatient hospitalization) COPD exacerbation in the previous year, despite receiving triple inhaled therapy?
   ❑ Yes ❑ No
7. Has the member tried and failed an adequate trial of Dupixent, unless contraindicated?
   ❑ Yes ❑ No ❑ N/A
   a. **If N/A was selected,** does the member have a peripheral blood eosinophil count < 300 cells/µL at screening?
   ❑ Yes ❑ No

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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.

1. Has the member been assessed for toxicity?
   ❑ Yes ❑ No ❑ N/A
2. Does the member have improvement in COPD symptoms or COPD exacerbations as evidenced by decrease in one or more of the following: **(check all that apply; chart notes must be submitted)**
   - Use of systemic corticosteroids
   - Use of antibiotics
   - Hospitalizations
   - ER visits
   - Unscheduled visits to healthcare provider
   - Improvement from baseline in forced expiratory volume in 1 second (FEV1)?

   ❑ Yes ❑ No

Medication being provided by Specialty Pharmacy - PropriumRx

*****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.****