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®, Exdensur®, 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®, Exdensur®, 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

   ***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. 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.*

REVISED/UPDATED/REFORMATTED: ~~9/11/2025;~~ **6/17/2026**