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: Veopoz™ (pozelimab) **(J9376) (Medical)**

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:** _____

❑ 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 Dosing: 12 mg/kg/dose once weekly; Maximum dose: 800 mg/dose.

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

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- ❑ Member must be 1 year of age or older
- ❑ Provider is a specialist in genetics or immunology, a hematologist, or other specialist in treatment of CHAPLE disease
- ❑ Member has a diagnosis of CD55-deficient protein-losing enteropathy (PLE) confirmed by biallelic CD55 loss-of-function mutation detected by genotype analysis **(submit documentation)**
- ❑ Member has active disease as defined as hypoalbuminemia (current serum albumin concentration of ≤3.2 g/dL) with at least **ONE** of the following signs or symptoms attributed to CD55-deficient PLE within the last six months **(check all that apply)**:
  - ❑ Abdominal pain
  - ❑ Diarrhea
  - ❑ Peripheral edema
  - ❑ Facial edema
- ❑ Medication will **NOT** be used in combination with other complement therapies or biologic medications (i.e., adalimumab, avacopan, culizumab, esutimlimab, pegcetacoplan, ravulizumab, ustekinumab)
- ❑ **ALL** the following criteria must be met:
  - ❑ Member will be administered a meningococcal vaccine (for serogroups A, C, W and Y, and serogroup B) at least two weeks prior to initiation of therapy and will continue to be revaccinated according to current medical guidelines for vaccine use
  - ❑ Member will be administered vaccinations for the prevention of Streptococcus pneumoniae and Haemophilus influenzae type b (Hib) infections according to medical guidelines
  - ❑ Member does **NOT** have an unresolved Neisseria meningitidis infection
  - ❑ Member will avoid concomitant therapy with intravenous immunoglobulin; if therapy is unavoidable, the patient will be monitored closely for adverse reactions and/or worsening of disease symptoms

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 experienced an absence of unacceptable toxicity from the drug (e.g., serious meningococcal infections (septicemia and/or meningitis), other serious bacterial infections, serious hypersensitivity reactions)
- ❑ Member has had positive clinical response to treatment as defined by a reduction or stabilization in **ALL** of the following as compared to pre-treatment baseline **(must submit current documentation)**:
  - ❑ Normalization/improvement in serum proteins (e.g., albumin, or immunoglobulin G)
  - ❑ Stabilization/improvement in signs and symptoms of disease
  - ❑ Reduction in albumin transfusion requirements, exogenous immunoglobulin, and/or hospitalization days

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Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – Proprium Rx**

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.