

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)
Severe Eosinophilic Asthma* (SEA)

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: _____

Recommended Dosage for Severe Asthma*:

- Adults and adolescents ≥ 12 years: 100 mg/mL SubQ, single-dose prefilled auto-injector or single dose prefilled syringe, once every 4 weeks
- Children ≥ 6 years to 11 years: 40 mg/mL SubQ, 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®, Fasentra®, 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®, Fasentra®, 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 6 years of age or older?
 Yes No
3. Does the member have a diagnosis of severe* asthma?
 Yes No
4. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥ 150 cells/ μ L?
 Yes No
5. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)?
 Yes No
5. Will this be used for add-on maintenance treatment in members regularly receiving **both** (unless otherwise contraindicated) of the following:
 - Medium- to high-dose inhaled corticosteroids; **AND**
 - An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers)? Yes No
6. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **or** one exacerbation resulting in a hospitalization?
 Yes No
7. Does the member have at least one of the following for assessment of clinical status:
 - Use of systemic corticosteroids
 - Use of inhaled corticosteroids
 - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
 - Forced expiratory volume in 1 second (FEV₁)? Yes No
8. Has the member tried and failed an adequate trial of the 2 different **preferred products (Fasenra[®] and Xolair[®])**?
 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
2. Has member had improvement in asthma symptoms or asthma 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
 - Hospitalizations
 - ER visits
 - Unscheduled visits to healthcare provider
 - Improvement from baseline in forced expiratory volume in 1 second (FEV1)? Yes No

***Components of severity for classifying asthma as *severe* may include any of the following (not all inclusive):**

- Symptoms throughout the day
- Nighttime awakenings, often 7 times per week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV1) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma.

Medication being provided by a 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.****