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:** _____

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 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®, 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 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/µL?
   ❑ Yes ❑ No
5. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)?
   ❑ Yes ❑ No
6. 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
7. 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
8. 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
9. **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):**

- Asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA
- Asthma that requires high-dose ICS-LABA to prevent it from being uncontrolled
- 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 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: ~~5/6/2016; 9/28/2016; 12/11/2016; 4/1/2017; 8/6/2017; 6/19/18; 7/13/2018; 3/212019; 7/7/2019; 9/15/2019; 4/27/2022; 6/16/2022; 9/15/2022; 2/22/2024, 5/24/2024; 6/19/2024; 6/20/2025,~~ **10/20/2025**