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) (Pharmacy) (Non-Preferred)
Eosinophilic Granulomatosis Polyangiitis (EGPA)*

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: 300 mg/mL SubQ once every 4 weeks administered as 3 separate 100-mg injections; single-dose prefilled auto-injector/single-dose prefilled syringe

***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 confirmed diagnosis of EGPA (aka Churg-Strauss Syndrome)?
   ❑ Yes ❑ No
4. Does the member have blood eosinophils ≥ 150 cells/µL within 6 weeks of dosing?
   ❑ Yes ❑ No
5. Has the member been on stable dose of concomitant oral corticosteroid therapy for at least 4 weeks (i.e., prednisone or prednisolone at a dose of 7.5 mg/day)?
   ❑ Yes ❑ No
6. Has the physician assessed baseline disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS], history of asthma symptoms and/or exacerbations, duration of remission, rate of relapses)?
   ❑ Yes ❑ No

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. Does the member have disease response as indicated by improvement in signs and symptoms compared to baseline as evidenced in one or more of the following:
   - Member is in remission [defined as a Birmingham Vasculitis Activity Score (BVAS) score=0 and a prednisone/prednisolone daily dose of ≤ 7.5 mg]
   - Decrease in maintenance dose of systemic corticosteroids
   - Improvement in BVAS score compared to baseline
   - Improvement in asthma symptoms or asthma exacerbations
   - Improvement in duration of remission or decrease in the rate of relapses?

   ❑ Yes ❑ No

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***Eosinophilic Granulomatosis Polyangiitis (EGPA) is defined as all the following:**

• History or presence of asthma
• Blood eosinophil level > 10% or an absolute count > 1000 cells/mm^3
• Two or more of the following criteria:
  ○ Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil rich granulomatous inflammation
  ○ Neuropathy
  ○ Pulmonary infiltrates
  ○ Sinonasal abnormalities
  ○ Cardiomyopathy
  ○ Glomerulonephritis
  ○ Alveolar hemorrhage
  ○ Palpable purpura
  ○ Antineutrophil Cytoplasmic Antibody (ANCA) positivity

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.