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® (mepolizumab) **(Pharmacy)**
Chronic rhinosinusitis with nasal polyps (CRSwNP)

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:** _____

Quantity Limit: 100 mg per 28 days

***Sentara Health Plans considers the use of concomitant therapy with Cinqair®, Nucala®, Dupixent®, Fasenra®, 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®, and/or Xolair® authorization on file, any subsequent requests for Nucala® will NOT be approved.**

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.

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❑ DIAGNOSIS: Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with an allergist, immunologist or otolaryngologist
- ❑ Member is 18 years of age or older
- ❑ Member has a **diagnosis of CRSwNP** confirmed by the American Academy of Otolaryngology-Head and Neck Surgery Clinical Practice Guideline (Update): Adult Sinusitis (AAO-HNSF 2015)/American Academy of Allergy Asthma & Immunology (AAAAI) with **ONE** of the following clinical procedures:
  - ❑ Anterior rhinoscopy
  - ❑ Nasal endoscopy
  - ❑ Computed tomography (CT)
- ❑ Documented diagnosis of chronic rhinosinusitis defined by at least 12 weeks of the following **(chart notes must be submitted)**:
  - ❑ Mucosal inflammation **AND** at least **TWO** of the following:
    - ❑ Decreased sense of smell
    - ❑ Facial pressure, pain, fullness
    - ❑ Mucopurulent drainage
    - ❑ Nasal obstruction
- ❑ Member is currently being treated with medications in at least **TWO** of the following categories unless there is a contraindication or intolerance to these medications and must be compliant on therapy **for at least 90 consecutive days** within a year of request **(chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes)**:
  - ❑ Nasal saline irrigation
  - ❑ Intranasal corticosteroids (e.g., fluticasone, budesonide, triamcinolone)
  - ❑ Leukotriene receptor antagonists (e.g., montelukast, zafirlukast, zileuton)
- ❑ Member is refractory, ineligible or intolerant to **ONE** of the following:
  - ❑ Systemic corticosteroids
  - ❑ Sino-nasal surgery
- ❑ Member is requesting Nucala® (mepolizumab) as add-on therapy to maintenance intranasal corticosteroids

Reauthorization Approval - 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 has experienced a positive clinical response to Nucala® therapy (e.g., reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, improved sense of smell) **(chart notes must be submitted)**

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- ❑ Decreased utilization of oral corticosteroids **(verified by pharmacy paid claims)**
- ❑ Member has been compliant on Nucala® therapy and continues to receive therapy with an intranasal corticosteroid **(verified by pharmacy paid claims)**

Medication being provided by (check box below that applies)**:**

❑ **Physician's office** **OR** ❑ **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.****

***Approved by Pharmacy and Therapeutic Committee:** 11/1/2021
REVISED/UPDATED: ~~12/13/2021; 12/23/2021,~~ **11/9/2023**