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.

The Sentara Health Plans Oncology Program is administered by OncoHealth

- **For any oncology indications**, the most efficient way to submit a prior authorization request is through the **OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us. Fax to **1-800-264-6128.** OncoHealth can also be contacted by Phone: 1-888-916-2616.

Drug Requested: Select drug below (Medical) (Non-Preferred)

❑ **Riabni™** (rituximab-arrx) **(Q5123)**	❑ **Rituxan®** (rituximab) **(J9312)**
❑ **Ruxience™** (rituximab-pvvr) **(Q5119)**	❑ **Truxima®** (rituximab-abbs) **(Q5115)**

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:** _____

❑ 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.

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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.

DIAGNOSES: Check below one of the diagnosis that applies to qualify.

❑ Rheumatoid Arthritis (RA)

- ❑ Prescriber is a rheumatologist

AND

- ❑ Member has a diagnosis of moderate- to-severe rheumatoid arthritis

AND

- ❑ Trial and failure of at least three (3) months of methotrexate therapy

AND

- ❑ Trial and failure of **BOTH** preferred medical biologics: Renflexis® IV **AND** Cimzia® IV

❑ Granulomatosis with Polyangiitis OR Microscopic Polyangiitis

INITIAL THERAPY [Ruxience, Truxima, Rituxan, Riabni]

- ❑ Prescriber is a rheumatologist or nephrologist

AND

- ❑ Member has a diagnosis of moderate- to-severe granulomatosis with polyangiitis

AND

- ❑ Member will receive concurrent therapy with corticosteroids

AND

- ❑ Member failed cyclophosphamide therapy

OR

- ❑ Member has a contraindication to cyclophosphamide therapy:

_____

_____

_____

_____

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❑ Granulomatosis with Polyangiitis OR Microscopic Polyangiitis

MAINTENANCE THERAPY [Ruxience, Truxima, Rituxan, Riabni]

- ❑ Prescriber is a rheumatologist or nephrologist

AND

- ❑ Induction occurred at least 4 months prior

AND

- ❑ Total duration of treatment does not exceed 24 months

AND

- ❑ Member failed methotrexate or azathioprine therapy

OR

- ❑ Member has a contraindication to methotrexate or azathioprine therapy:

_____

_____

_____

_____

❑ Neuromyelitis Optica Spectrum Disorder (NMOSD) [Ruxience, Truxima, Rituxan, Riabni]

- ❑ Prescribing physician must be a neurologist

AND

- ❑ Member must be 18 years of age or older

AND

- ❑ Provider must submit medical records (e.g. chart notes) confirming the member has a diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) based on the following:
  - ❑ Member was found to be seropositive for aquaporin-4 (AQP4) IgG antibodies; **AND**
  - ❑ Member has at least one core clinical characteristic (see chart below)

OR

  - ❑ Member was found to be seronegative for AQP-4 IgG antibodies OR has unknown AQP-4- IgG status; **AND**
  - ❑ Member has at least two core clinical characteristics occurring as a result of one or more clinical attacks (see chart below); **AND**

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- ❑ Member experienced **ALL** the following:
  - ❑ At least 1 core clinical characteristic must be optic neuritis, acute myelitis with LETM*, or area postrema syndrome
  - ❑ Dissemination in space (≥ 2 different core clinical characteristics)
  - ❑ Fulfillment of additional MRI requirements, as applicable (see chart below)

AND

- ❑ Alternative diagnoses have been excluded (e.g., multiple sclerosis, sarcoidosis, cancer, chronic infection, etc.)

AND

- ❑ Member must have failed at least **ONE** of the following treatment options:
  - ❑ Oral therapy with azathioprine, methotrexate, mitoxantrone or mycophenolate
  - ❑ Member has required plasmapheresis or plasma exchange (PE) or intravenous Immunoglobulin (IVIG)

Core Clinical Characteristics of NMOSD
• Optic neuritis • Acute myelitis • Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting • Acute brainstem syndrome • Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions • Symptomatic cerebral syndrome with NMOSD-typical brain lesions
Core Clinical Characteristics of NMOSD
• Acute optic neuritis: requires brain MRI showing (a) normal findings or only nonspecific white matter lesions, OR (b) optic nerve MRI with T2-hyperintense lesion or T1-weighted gadolinium- enhancing lesion extending over >1/2 optic nerve length or involving optic chiasm • Acute myelitis: requires associated intramedullary MRI lesion extending over ≥3 contiguous segments (LETM) OR ≥3 contiguous segments of focal spinal cord atrophy in patients with history compatible with acute myelitis • Area postrema syndrome: requires associated dorsal medulla/area postrema lesions • Acute brainstem syndrome: requires associated peri-ependymal brainstem lesions

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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**

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.

***Approved by Pharmacy and Therapeutics Committee**: ~~5/21/2020;~~ **2/15/2021**
REVISED/UPDATED/REFORMATTED: ~~9/10/2020; 4/1/2021; 6/14/2021; 10/11/2021; 11/22/2021; 12/12/2023; 12/20/2024;~~ **2/28/2025**