SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-844-305-2331**. 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**.

Drug Requested: Uplizna™ (inebilizumab-cdon) IV (Medical)

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.

Recommended Dosage: Maximum Units (per dose and over time)

- 300 billable units on day 1 and 15, then 300 billable units every 6 months (beginning 6 months after the first dose)
- Initial dose: 300 mg IV infusion, followed by a second 300 mg IV infusion two weeks later
- Subsequent doses (starting 6 months from the first infusion): single 300 mg IV infusion every 6 months

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: Neuromyelitis Optica Spectrum Disorder (NMOSD)

Initial Authorization and Reauthorization: 12 months

- ❑ Member must be 18 years of age or older
- ❑ Member has a confirmed diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) confirmed by blood serum test for anti-aquaporin- 4 antibody positive (AQP4-IgG)
- ❑ Prescriber attests that member has been screened for hepatitis B virus (HBV) and tuberculosis (TB) prior to initiating treatment and member does not have an active infection
- ❑ Prescriber attestation that member is not concomitantly receiving therapy with other immunosuppressant type drugs
- ❑ Prescriber attestation that member will not be using in combination with complement-inhibitor (i.e., eculizumab, ravulizumab) or antiCD20-directed antibody (i.e., rituximab) therapies
- ❑ Member has documentation history to one of the following:
  - ❑ One or more relapses that required rescue therapy within the previous 12 months
  - ❑ Two or more relapses that required rescue therapy in 2 years prior to screening
- ❑ Member has documentation of a baseline Expanded Disability Status Scale (EDSS) score ≤ 8
- ❑ Member has a baseline relapse rate and visual acuity

❑ Diagnosis: Immunoglobulin G4-related disease (IgG4-RD)

Initial Authorization and Reauthorization: 12 months

- ❑ Member must be 18 years of age or older
- ❑ Member has a confirmed diagnosis of Immunoglobulin G4-related disease (IgG4-RD)
- ❑ Prescriber attests that member has been screened for hepatitis B virus (HBV) and tuberculosis (TB) prior to initiating treatment and member does not have an active infection
- ❑ Prescriber attestation that member is not concomitantly receiving therapy with other immunosuppressant type drugs
- ❑ Member is experiencing (or recently experienced) an IgG4-RD flare that required corticosteroid treatment and one of the following:
  - ❑ Disease that is refractory to corticosteroids
  - ❑ Contraindication or intolerance to corticosteroid treatment
- ❑ Member is at high risk of recurrent disease flares based on a history of disease in ≥2 organs/site
- ❑ At least one of the following organs are affected: Pancreas, bile ducts/biliary tree, orbits, lungs, kidneys, lacrimal glands, major salivary glands, retroperitoneum, aorta, pachymeninges, and/or thyroid gland

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❑ Diagnosis: Myasthenia Gravis (gMG)

Initial Authorization and Reauthorization: 12 months

- ❑ Member must be 18 years of age or older
- ❑ Prescribed by, or in consultation with, a neurologist or other specialist in myasthenia gravis
- ❑ Member has been screened for hepatitis B virus (HBV) and tuberculosis (TB) prior to initiating treatment and member does not have an active infection
- ❑ Member has a Myasthenia Gravis-Activities of Daily Living (MG-ADL) score between 6 and 10 with > 50% of this score attributed to non-ocular items or an MG-ADL score ≥ 11
- ❑ Member has a Myasthenia Gravis Foundation of America (MGFA) clinical classification class of II-IVb
- ❑ Member has tried and had an inadequate response after an adequate trial to at least two immunosuppressive therapies (e.g. azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) (either combination or monotherapy) **OR**
- ❑ Member has tried and had an inadequate response after an adequate trial to treatment to at least one immunosuppressive therapy (e.g. azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) **AND** one of the following:
  - Member required chronic intravenous immunoglobulin (IVIG) **OR**
  - Member required chronic plasmapheresis/plasma exchange

Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health'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**: 11/19/2020
REVISED/UPDATED/REFORMATTED: ~~4/1/2021; 6/14/2021, 6/7/2024; 6/20/2025 1/21/2026;~~ **3/20/2026**