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 (J3590) NDC 72677-0551-01 (Medical)**
Neuromyelitis Optica Spectrum Disorder (NMOSD)

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:** _____

☐ 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

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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

- ❑ Prescribing physician must be a neurologist

AND

- ❑ Member must be 18 years of age or older

AND

- ❑ Diagnosis of NMOSD confirmed by blood tests for anti-aquaporin-4 immunoglobulin G (AQP4-IgG) antibodies **(must submit lab results)**

AND

- ❑ Prescriber attestation 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

AND

- ❑ Prescriber attestation that member is not concomitantly receiving therapy with other immunosuppressant type drugs

AND

- ❑ Prescriber attestation that member will not be using in combination with complement-inhibitor (i.e., eculizumab, ravulizumab) or anti-CD20-directed antibody (i.e., rituximab) therapies

AND

- ❑ Member has documentation history of
  - ❑ One or more relapses that required rescue therapy within the previous 12 months

OR

  - ❑ Two or more relapses that require rescue therapy in 2 years prior to screening

AND

- ❑ Member has documentation of baseline Expanded Disability Status Scale (EDSS) score ≤8

AND

- ❑ Member has documentation of baseline relapse rate and visual acuity

Reauthorization: 6 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 continues to meet the initial criteria

AND

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- ❑ Absence of unacceptable toxicity from therapy (i.e., tuberculosis (TB) infections, hepatitis B reactivation, infusion reactions, serious infections, Progressive Multifocal Leukoencephalopathy (PML), hypogammaglobulinemia, etc.)

AND

- ❑ Provider must submit clinical notes documenting clinical improvement (fewer relapses from baseline) or stabilization of patient relapses while on Uplizna™ therapy.

  Note: Add on, dose escalation of immunosuppressive therapy, or additional rescue therapy from baseline to treat NMOSD or exacerbation of symptoms while on therapy will be considered as treatment failure. Uplizna™ therapy has not been studied with other immunosuppressants.

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

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

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy – PropriumRx**

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'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.****