# 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) **(J2182) (Medical)**
**{Hypereosinophilic Syndrome (HES)}**

**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 Name/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.

**IF REQUIRED, TYPE RECOMMENDED DOSAGE AND/OR QUANTITY LIMITS**

**Recommended Dosage:** 300mg/mL SubQ once every 4 weeks administered as 3 separate 100-mg injections

- **The Health Plan 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® or Xolair authorization on file, any subsequent request 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 Approval Length – 12 months**

❑ Member is ≥ 12 years of age

**AND**

❑ Prescriber is or has consulted with an Allergist, Immunologist, Pulmonologist or Rheumatologist

**AND**

❑ Member has a diagnosis of HES for 6 months or longer without any non-hematologic secondary cause (i.e. drug hypersensitivity, parasitic helminth infection, human immunodeficiency virus infection, non-hematologic malignancy) **(submit chart notes and labs confirming diagnosis)**

**AND**

❑ Member has FIP1L1-PDGFRα-negative disease

**AND**

❑ Member has had two or more episodes of HES-related flares (worsening of clinical symptoms and/or worsening of blood eosinophil counts) requiring escalation of therapy in the past 12 months **(submit chart notes)**

**AND**

❑ Member's HES-related flares occur spontaneously and did NOT occur within 4 weeks of a decrease in therapy

**AND**

❑ Member has been on a stable dose of HES therapy (such as oral corticosteroids, immunosuppressive agents and/or cytotoxic therapy) for the past 4 or more weeks **(verified by pharmacy paid claims)**

**AND**

❑ Member's blood eosinophil count is ≥ 1000 cells/microliter while taking stable doses of HES therapy **(submit labs obtained within 4 weeks of request)**

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**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.

- ❑ The member has experienced a positive response to Nucala™ therapy as determined by the prescriber (i.e. decreased number of flares, improved fatigue, reduced corticosteroid requirements, and decreased eosinophil levels) **(submit chart notes)**

**Medication being provided by (check applicable box(es) below):**

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

  **NPI or DEA # of administering location:** _____

  **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 Therapeutics Committee:** 01/21/2021
**REVISED/UPDATED/REFORMATTED:** ~~6/30/2021~~, ~~11/9/2023~~, **02/22/2024**