# 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: Brinsupri™** (brensocatib)

**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:** _____

**Recommended Dosage:** 10 mg or 25 mg once daily

**Quantity Limit:** 30 tablets per 30 days (both strengths)

**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: 12 months**

- ❑ Member must be ≥ 12 years of age or older
- ❑ Prescribed by or in consultation with a pulmonologist
- ❑ Member has bronchiectasis diagnosed by chest computed tomography in the last five years **(submit documentation)**

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- ❑ Member must meet **ONE** of the following **(submit documentation)**:
  - ❑ **For members ≥ 12 years of age and < 18 years of age**: Member has a history of at least one pulmonary exacerbation during the previous 12 months requiring an antibiotic prescription, urgent care or emergency room visit, or hospitalization prior to initiating Brinsupri™
  - ❑ **For members ≥ 18 years of age**: Member has a history of at least two pulmonary exacerbations during the previous 12 months requiring an antibiotic prescription, urgent care or emergency room visit, or hospitalization, prior to initiating Brinsupri™

    **[NOTE: A pulmonary exacerbation is defined as worsening of three or more of the following major symptoms over 48 hours: increased cough, increased sputum volume or change in sputum consistency, increased sputum purulence, increased breathlessness, decreased exercise tolerance, fatigue and/or malaise, and hemoptysis.]**
- ❑ Member does **NOT** have cystic fibrosis
- ❑ Provider attests bronchiectasis is **NOT** driven primarily by other comorbid respiratory conditions (e.g., asthma, chronic obstructive pulmonary disease (COPD), alpha-1 antitrypsin deficiency, and known or suspected immunodeficiency disorders)
- ❑ Member is a current non-smoker
- ❑ Member has been receiving or has tried and failed standard therapies for bronchiectasis, including **ALL** the following where clinically appropriate **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ **Antibiotics:**
    - ❑ Chronic or intermittent macrolide therapy (e.g., azithromycin)
    - ❑ Other systemic antibiotics (e.g., β-lactams or tetracyclines)
    - ❑ Inhaled antibiotics (e.g., tobramycin, aztreonam)
  - ❑ **Expectorants and mucolytics:**
    - ❑ e.g., hypertonic saline, dornase alfa, mannitol, or acetylcysteine
  - ❑ **Airway clearance techniques:**
    - ❑ e.g., chest physiotherapy, mechanical percussion vests, or breathing techniques
  - ❑ **Other adjunct therapies**, as clinically indicated:
    - ❑ Inhaled bronchodilators
    - ❑ Anti-inflammatory medications
    - ❑ Management of gastroesophageal reflux disease (GERD)
- ❑ Prescribed dose does **NOT** exceed the maximum daily dose of one per day for 10 mg or 25 mg strength tablets

**Reauthorization: 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 continues to meet all initial authorization criteria

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- ❑ Provider attests to an absence of unacceptable toxicity from therapy (e.g., hyperkeratosis and periodontitis or gingivitis, severe infections)
- ❑ Provider must submit clinical notes documenting clinical improvement (e.g., reduction in the number of exacerbations or preservation of lung function) while on Brinsupri™

**Medication being provided by Specialty Pharmacy – Proprium Rx**

***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: 9/25/2025**
**REVISED/UPDATED/REFORMATTED: 10/22/2025**