

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 \geq 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 \geq 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 \geq 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 tried and failed antibiotics and other optimal supportive treatments for bronchiectasis including the following where clinically appropriate (**check all that apply; 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.****