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) **(Pharmacy) (Non-Preferred)**
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 Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

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®, Dupixent®, Fasenra®, Tezspire™ 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®, Tezspire™ or Xolair® authorization on file, all subsequent requests for Nucala® will NOT be approved.**

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 – 6 months

(Continued on next page)

1. Has the member been approved for Nucala® previously through the Sentara medical department?
   ❑ Yes ❑ No
2. Is the member 12 years of age or older?
   ❑ Yes ❑ No
3. Has the member been diagnosed with HES (without an identifiable non-hematologic secondary cause (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy) or FIP1L1- PDGFRα kinase-positive HES) for at least 6 months prior to starting treatment?
   ❑ Yes ❑ No
4. Has the member had a history of 2 or more HES flares within the previous 12 months (e.g., documented HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy)?
   ❑ Yes ❑ No
5. Will this be used in combination with stable doses of at least one other HES therapy, (e.g., oral corticosteroids, immunosuppressive agents, cytotoxic therapy) unless the member cannot tolerate other therapy?
   ❑ Yes ❑ No

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.

1. Has the member been assessed for toxicity?
   ❑ Yes ❑ No
2. Has the member had a disease response as indicated by a decrease in HES flares from baseline?

   Note: An HES flare is defined as worsening of clinical signs and symptoms of HES or increasing eosinophils (on at least 2 occasions), resulting in the need to increase oral corticosteroids or increase/add cytotoxic or immunosuppressive HES therapy. **(submit chart notes)**

   ❑ Yes ❑ No

Medication being provided by a 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.