SENTARA HEALTH PLAN

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 1-844-668-1550**. 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**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Briumvi™ (ublituximab) Injection (J3590/C9399) (Medical)

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 and Administration:

- **Initial dose: 150 mg intravenous infusion, followed 2 weeks later by a 2nd 450 mg intravenous infusion**
- **Subsequent doses: single 450 mg intravenous 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

- ❑ Prescriber is a Neurologist
- ❑ Member is 18 years of age or older
- ❑ Member must have **ONE** of the following confirmed relapsing forms of multiple sclerosis (MS):
  - ❑ Relapsing-remitting MS (RRMS)
  - ❑ Active Secondary-progressive MS (SPMS)
  - ❑ Clinically Isolated Syndrome (CIS)
- ❑ Member has tried and failed at least **TWO (2)** of the following agents **(verified by chart notes or pharmacy paid claims; check each tried):**

❑ Aubagio® (teriflunomide)	❑ Avonex® (IFN beta-1b)	❑ Bafiertam® (monomethyl fumarate)
❑ Betaseron® (IFN beta-1a)	❑ Copaxone® (glatiramer acetate)	❑ Extavia® (IFN beta-1a)
❑ Gilenya® (fingolimod)	❑ Kesimpta® (ofatumumab)	❑ Lemtrada® (alemtuzumab) **(requires medical prior authorization)**
❑ Mavenclad® (cladribine)	❑ Mayzent® (siponimod)	❑ Ocrevus ® (ocrelizumab)
❑ Plegridy® (pegylated-IFN beta- 1a)	❑ Rebif® (IFN beta-1a)	❑ Tecfidera® (dimethyl fumarate)
❑ Vumerity® (diroximel fumarate)	❑ Zeposia® (ozanimod)	❑ Tysabri® (natalizumab) **(requires medical prior authorization)**

- ❑ Prescriber attestation to **ALL** the following:
  - ❑ Testing for quantitative serum immunoglobulins prior to initiation of therapy
  - ❑ Member does **NOT** have an active infection with hepatitis B virus
  - ❑ Medication will **NOT** be given concurrently with live vaccines
  - ❑ Member has had at least **ONE** medically documented clinical relapse within the previous 12 months
  - ❑ Member does **NOT** have concurrent use of other MS disease modifying agents

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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 demonstrate a positive clinical response to therapy
- ❑ Member has **NOT** developed any contraindications or other significant adverse effects that may exclude continued use
- ❑ Member does **NOT** have concurrent use of other MS disease modifying therapies

Medication being provided by: Please check applicable box below.

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

  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara'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.

***Approved by the Pharmacy and Therapeutic Committee**:
UPDATED/REVISED: 3/30/2023