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: Uplizna™ (inebilizumab-cdon) **IV (Pharmacy)**

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: Maximum Units (per dose and over time)

- 300 billable units on day 1 and 15, then 300 billable units every 6 months (beginning 6 months after the first dose)
- Initial dose: 300 mg IV infusion, followed by a second 300 mg IV infusion two weeks later
- Subsequent doses (starting 6 months from the first infusion): single 300 mg IV infusion every 6 months

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.

(Continued on next page)

❑ Diagnosis: Neuromyelitis Optica Spectrum Disorder (NMOSD)

Initial Authorization and Reauthorization: 12 months

- ❑ Member must be 18 years of age or older
- ❑ Member has a confirmed diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) confirmed by blood serum test for anti-aquaporin- 4 antibody positive (AQP4-IgG)
- ❑ Prescriber attests that member has been screened for hepatitis B virus (HBV) and tuberculosis (TB) prior to initiating treatment and member does not have an active infection
- ❑ Prescriber attestation that member is not concomitantly receiving therapy with other immunosuppressant type drugs
- ❑ Prescriber attestation that member will not be using in combination with complement-inhibitor (i.e., eculizumab, ravulizumab) or antiCD20-directed antibody (i.e., rituximab) therapies
- ❑ Member has documentation history to one of the following:
  - ❑ One or more relapses that required rescue therapy within the previous 12 months
  - ❑ Two or more relapses that required rescue therapy in 2 years prior to screening
- ❑ Member has documentation of a baseline Expanded Disability Status Scale (EDSS) score ≤ 8
- ❑ Member has a baseline relapse rate and visual acuity

❑ Diagnosis: Immunoglobulin G4-related disease (IgG4-RD)

Initial Authorization and Reauthorization: 12 months

- ❑ Member must be 18 years of age or older
- ❑ Member has a confirmed diagnosis of Immunoglobulin G4-related disease (IgG4-RD)
- ❑ Prescriber attests that member has been screened for hepatitis B virus (HBV) and tuberculosis (TB) prior to initiating treatment and member does not have an active infection
- ❑ Prescriber attestation that member is not concomitantly receiving therapy with other immunosuppressant type drugs
- ❑ Member is experiencing (or recently experienced) an IgG4-RD flare that required corticosteroid treatment and one of the following:
  - ❑ Disease that is refractory to corticosteroids
  - ❑ Contraindication or intolerance to corticosteroid treatment
- ❑ Member is at high risk of recurrent disease flares based on a history of disease in ≥2 organs/site
- ❑ At least one of the following organs are affected: Pancreas, bile ducts/biliary tree, orbits, lungs, kidneys, lacrimal glands, major salivary glands, retroperitoneum, aorta, pachymeninges, and/or thyroid gland

(Continued on next page)

❑ Diagnosis: Myasthenia Gravis (gMG)

Initial Authorization and Reauthorization: 12 months

- ❑ Member must be 18 years of age or older
- ❑ Prescribed by, or in consultation with, a neurologist or other specialist in myasthenia gravis
- ❑ Member has been screened for hepatitis B virus (HBV) and tuberculosis (TB) prior to initiating treatment and member does not have an active infection
- ❑ Member has a Myasthenia Gravis-Activities of Daily Living (MG-ADL) score between 6 and 10 with > 50% of this score attributed to non-ocular items or an MG-ADL score ≥ 11
- ❑ Member has a Myasthenia Gravis Foundation of America (MGFA) clinical classification class of II-IVb
- ❑ Member has tried and had an inadequate response after an adequate trial to at least two immunosuppressive therapies (e.g. azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) (either combination or monotherapy) **OR**
- ❑ Member has tried and had an inadequate response after an adequate trial to treatment to at least one immunosuppressive therapy (e.g. azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus, methotrexate, cyclophosphamide) **AND** one of the following:
  - Member required chronic intravenous immunoglobulin (IVIG) **OR**
  - Member required chronic plasmapheresis/plasma exchange

Medication being provided by 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**: 11/19/2020
REVISED/UPDATED/REFORMATTED: ~~6/20/2025; 1/21/2026;~~ **3/20/2026**