# 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 information provided is not complete, correct, or legible, authorization 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

## 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.***