OPTIMA HEALTH PLAN

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; **(Pharmacy) 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: Revcovi™ (elapegademase-lvlr) **(Pharmacy)**

DRUG INFORMATION: Complete information below or authorization will be delayed if incomplete.

Drug Form/Strength: _____

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

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

Dosing Limit: (see below)

A. Quantity Limit (max daily dose): Pharmacy Benefit - 2.4 mg/1.5 mL single dose vial: 20 vials per 7 days

B. Max Units (per dose and over time): Medical Benefit (J3590) - 23 mg twice weekly

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes **must** be submitted or request will be denied.

Initial Authorization Approval – 12 months

- **Coverage is provided in the following conditions:**
  - ❑ Must not be used in combination with pegademase-bovine

    AND
  - ❑ Member has severe combined immunodeficiency disease (SCID) with a definitive diagnosis of adenosine deaminase deficiency as determined by one of the following:
    - ❑ Deficient ADA catalytic activity (<1% of normal) in hemolysates (in untransfused individuals) or in extracts of other cells (e.g., blood mononuclear cells, fibroblasts)

      OR
    - ❑ Detection of pathogenic mutations in the ADA gene by molecular genetic testing;

      AND
  - ❑ Member has a marked elevation of the metabolite dATP or total dAdo nucleotides (the sum of dAMP, dADP and dATP) in erythrocytes;

    AND
  - ❑ Member is not a candidate for or has failed hematopoietic cell transplantation (HCT);

    AND

(Continued on next page)

- ❑ Member does not have severe thrombocytopenia (<50,000/microL);

AND

- ❑ Baseline lab values for plasma ADA activity, red blood cell deoxyadenosine triphosphate (dATP), trough deoxyadenosine nucleotide (dAXP) levels and/or total lymphocyte counts must be submitted with this request
- ❑ Is the member transitioning from Adagen® to Revcovi™? ❑ Yes ❑ No
- ❑ Member's current height and weight must be noted and dosing will be based on ideal body weight

  Height: _____ Weight: _____

<u>Reauthorization of Therapy:</u> Yearly reauthorization is required for continuation of therapy. (12 month approval)

CLINICAL CRITERIA: Check below **ALL** that apply**. ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes **must** be submitted or request will be denied**.**

- **Authorizations can be renewed based on the following criteria:**

- ❑ Member continues to meet the criteria identified in Initial Approval Section.

AND

- ❑ Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include severe injection site reactions (e.g., bleeding), severe thrombocytopenia, etc.;

AND

- ❑ Adequate documentation of disease stability and/or improvement as indicated by one or more of the following must be submitted:
  - ❑ Increase in plasma ADA activity (target trough level ≥ 15 mmol/hr/L)
  - ❑ Red blood cell dATP level decreased (target ≤ 0.005 to 0.015 mmol/L)
  - ❑ Improvement in immune function with diminished frequency/complications of infection as evidenced in improvement in the ability to produce antibodies
  - ❑ Improvement in red blood cell dAXP levels (target trough level ≤ 0.02 mmol/L)
- ❑ Member's current height and weight must be noted and dosing will be based on ideal body weight

  Height: _____ Weight: _____

Medication being provided by Specialty Pharmacy - PropriumRx

(continued on next page; signature page <u>must</u> be attached to this request form)

(**Signature page MUST be included with request form)**

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.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 3/21/2019;
REVISED/UPDATED: 5/28/2019