SENTARA HEALTH PLANS

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: Nulojix® (belatacept) **(J0485)**

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.

A. Max Units (per dose and over time) [NDC/HCPCS Unit]:

- 250 mg solution per 1 vial; NDC 0003-0371-13; 250 billable units

Note: Dosing is based on actual body weight at the time of transplantation

- ❖ Do not modify weight-based dosing during course of therapy unless the change in body weight is >10%
- ❖ The prescribed dose must be evenly divisible by 12.5 mg in order for the dose to be prepared accurately using the provided required disposable syringe for preparation

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EXAMPLE:

- A patient weighs 64 kg. The dose is 10 mg per kg
- Calculated Dose: 64 kg × 10 mg per kg = 640 mg
- The closest doses evenly divisible by 12.5 mg below and above 640 mg are 637.5 mg and 650 mg
- The nearest dose to 640 mg is 637.5 mg
- Therefore, the actual prescribed dose for the patient should be 637.5 mg

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: 4 months

- ❑ Member is 18 years of age or older
- ❑ Prescribed by or in consultation with a kidney transplant specialist
- ❑ Therapy is being requested for kidney transplant rejection prophylaxis meeting **BOTH** of the following:
  - ❑ Medication will be used in combination with basiliximab induction, mycophenolate mofetil, and corticosteroids
  - ❑ Member is Epstein-Barr virus (EBV) seropositive **(please provide medical/laboratory documentation and results)**

    NOTE: Belatacept will not be approved for transplant recipients who are EBV seronegative or with unknown serostatus
- ❑ Provider confirms that dose will not exceed the following **(please provide medical documentation, chart notes, therapy plan, and scheduled date of transplant)**:
  - ❑ **For the Initial Phase**: 10 mg/kg on day 1 (day of transplant, prior to implantation) and on day 5 (~96 hours after day 1 dose), followed by 10 mg/kg at the end of week 2, week 4, week 8, and week 12 following transplantation

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.

- ❑ Provider confirms that dose will **NOT** exceed the following **(please provide medical documentation, chart notes, and scheduled therapeutic plan for confirmation)**:
  - ❑ **For the Maintenance Phase:** 5 mg/kg every 4 weeks (±3 days) beginning at the end of week 16 following transplantation
- ❑ Member is responding positively to treatment
- ❑ Member has **NOT** experienced unacceptable toxicity from the drug (e.g., latent viral infections, signs of lymphoproliferative disorders)

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Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan'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 Pharmacy and Therapeutics Committee**: 7/21/2022
REVISED/UPDATED: 8/10/2022