

OPTIMA HEALTH FAMILY CARE (MEDICAID)

MEDICAL/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 1-844-723-2094. 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 will be delayed.

Drug Requested: Nucala™ SQ (mepolizumab) (J2182) (Medical)
{Eosinophilic Granulomatosis Polyangiitis (EGPA)}

URGENT REVIEW. In checking this box, prescriber attests to the fact that by applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function.

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.

DRUG INFORMATION: Complete **all** information below or authorization will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

RECOMMENDED DOSAGE:

300mg SubQ once every 4 weeks administered as 3 separate 100-mg injections

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 will be denied.

Initial Approval Length – 12 months

Medication must be prescribed by an allergist, immunologist, or pulmonologist;

AND

Member must be 18 years of age or older;

AND

Member must have diagnosis of Eosinophilic Granulomatosis with Polyangiitis (EGPA) (Churg-Strauss Syndrome) \geq 6 months based on the history or presence of asthma;

AND

Eosinophilia $>10\%$ (**must submit labs for documentation**);

AND

(Continued on next page)

- ❑ Member **must** have documentation of **TWO** of the following (**include documentation**):
 - ❑ A biopsy showing evidence of EGPA
 - ❑ Mono-or polyneuropathy
 - ❑ Pulmonary infiltrates, non-fixed on chest x-rays
 - ❑ Sino-nasal abnormality
 - ❑ Magnetic Resonance Imaging or Echocardiography of cardiomyopathy
 - ❑ Glomerulonephritis
 - ❑ Alveolar hemorrhage (by bronchoalveolar lavage)
 - ❑ Palpable purpura
 - ❑ Anti-neutrophil cytoplasmic anti-body (ANCA) positive (Myeloperoxidase or proteinase 3)

AND

- ❑ History of relapsing **OR** refractory disease defined as (**MUST** select one of the following):
 - ❑ **Relapsing disease:**
 - ❑ Must have a past history of at least one confirmed EGPA relapse requiring:
 - ❑ An increase in oral corticosteroids (OCS) dose
 - ❑ Initiation or increased dose of immunosuppressive therapy (e.g., cyclophosphamide, methotrexate, azathioprine or mycophenolate mofetil)
 - ❑ Hospitalization
 - ❑ Must have occurred ≥ 12 weeks but < 2 years prior to initiation while receiving a dose of prednisone (or equivalent) of ≥ 7.5 milligram per day (mg/day) for **at least 90 consecutive days**
 - ❑ **Refractory disease:**
 - Either:
 - ❑ Failure to attain remission (Birmingham Vasculitis Activity Score (BVAS)=0) and OCS dose ≤ 7.5 mg/day prednisone or equivalent) for **at least 90 consecutive days** within the last 6 months following induction treatment with a standard regimen (e.g., cyclophosphamide, methotrexate, azathioprine, mycophenolate mofetil, or high-dose corticosteroids (≥ 15 mg/day prednisone), administered for at least 3 months.

OR

- ❑ Within 6 months prior to initiation, recurrence of symptoms of EGPA while tapering oral corticosteroids (OCS), occurring at any dose level ≥ 7.5 mg/day prednisone or equivalent taken for **at least 90 consecutive days.**

Exclusion Criteria. Therapy will not be approved if member has history of any of the following:

- ❑ Organ/life threatening EGPA within 3 months prior to initiation

(Continued on next page)

- Malignancy: current malignancy or previous history of cancer in remission for < 12 months
- Unstable cardiovascular disease: Ejection fraction < 20%, New York Heart Association Class III/IV failure, acute myocardial infarction diagnosed less than 3 months
- Unstable liver disease: Presence of ascites, encephalopathy, coagulopathy, hypoalbuminemia, esophageal or gastric varices, cirrhosis, and known biliary abnormalities (with the exception of Gilbert's syndrome or asymptomatic gallstones)
- Rituximab within the past year; IVIg within the past 6 months; omalizumab within the past 4 months
- Pregnancy, breast-feeding, absence of contraception if female of child-bearing age

REAUTHORIZATION APPROVAL - 12 MONTHS. Check below **ALL** that apply to qualify. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

- Documentation of remission or improvement in the Birmingham Vasculitis Activity Score (BVAS) or prednisone/prednisolone daily dose of ≤ 7.5 mg

OR

- Documentation of decrease in maintenance dose of systemic corticosteroids, improvement in asthma symptoms or asthma exacerbations

OR

- Documentation of disease flares with tapering of corticosteroid therapy or immunotherapy

Medication being provided by a 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.****

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: 2/15/2018

REVISED/UPDATED: 6/29/2018; 8/27/2018; 10/8/2018; (Reformatted) 2/6/2019; 5/5/2019; 7/17/2019;