



**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  $\geq 12$  weeks but  $< 2$  years prior to initiation while receiving a dose of prednisone (or equivalent) of  $\geq 7.5$  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  $\leq 7.5$  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 ( $\geq 15$  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  $\geq 7.5$  mg/day prednisone or equivalent taken for **at least 90 consecutive days.**

**Exclusions (therapy will not be approved if member has history of any of the following):**

- Organ/life threatening EGPA within 3 months prior to initiation
- QTc(F)  $\geq 450$  msec ( $\geq 480$  if bundle branch block)
- Malignancy (unless in remission for  $>1$  year), unstable liver or cardiovascular disease
- 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

**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  
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