OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION 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 1-844-202-5034. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.***

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

DRUG INFORMATION: Complete information below or authorization process 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: ALL criteria MUST be met to qualify for approval. Chart notes, including labs, MUST be submitted with this request or authorization process will be delayed.

- ❑ 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) ≥ 6 months based on the history or presence of asthma; **AND**
  - ❑ Eosinophilia >10% ***(must submit labs for documentation)***; **AND**
- ❑ Member must have documentation of **TWO** of the following ***(chart notes/labs/diagnostics must be submitted for 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 bronchoalveloar 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.***

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- ❑ ***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*.**

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) ≥450 msec (≥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 – Briova SpecialtyRx

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: 7/10/2018