HIGHMARK WHOLECARE

Updated: 04/2022
PARP Approved: 6/2022

Prior Authorization Criteria

# Uplizna (Inebilizumab-cdon)

All requests for Uplizna (Inebilizumab-cdon) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

For all requests for Uplizna (Inebilizumab-cdon) all of the following criteria must be met in addition to the diagnosis specific criteria below:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Coverage may be provided with a diagnosis of Neuromyelitis Optica Spectrum Disorder (NMOSD) and the following criteria is met:

- Medication is prescribed by, or in consultation with a neurologist
- Documentation of a positive test for AQP4-IgG antibodies
- Documentation of at least 1 relapse in the last 12 months or 2 or more relapses that required rescue therapy in the last 24 months
- Documentation of an Expanded Disability Status Scale (EDSS) score of $\leq 8$
- Must have documentation of inadequate response, contraindication or intolerance to rituximab or any of its biosimilars.
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Documentation from the prescriber indicating stabilization or improvement in condition.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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# UPLIZNA (INEBILIZUMAB_CDON) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Wholecare Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

## PROVIDER INFORMATION

| | |
|---|---|
| Requesting Provider: | Provider NPI: |
| Provider Specialty: | Office Contact: |
| State license #: | Office NPI: |
| Office Address: | Office Phone: |
| | Office Fax: |

## MEMBER INFORMATION

| | | |
|---|---|---|
| Member Name: | DOB: | |
| Member ID: | Member weight: | Height: |

## REQUESTED DRUG INFORMATION

| | | |
|---|---|---|
| Medication: | Strength: | |
| Directions: | Quantity: | Refills: |
| Is the member currently receiving requested medication? ☐ Yes ☐ No | Date Medication Initiated: | |

## Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

## Place of Service Information

| | |
|---|---|
| Name: | NPI: |
| Address: | Phone: |

## MEDICAL HISTORY (Complete for ALL requests)

| | |
|---|---|
| Diagnosis: | ICD Code: |

Is documentation of a positive test for AQP4-IgG antibodies provided? ☐ Yes ☐ No

What is the member's Expanded Disability Status Scale (EDSS) score? _____

Has the member had at least 1 relapse that required rescue therapy in the last 12 months or 2 or more relapses that required rescue therapy in the last 24 months? ☐ Yes ☐ No

## CURRENT or PREVIOUS THERAPY

| Medication Name | Strength/ Frequency | Dates of Therapy | Status (Discontinued & Why/Current) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No If **Yes,** please include documentation.

## SUPPORTING INFORMATION or CLINICAL RATIONALE

| | |
|---|---|
| **Prescribing Provider Signature** | Date |
| | |

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**DRUG NAME**

**PRIOR AUTHORIZATION FORM (CONTINUED)– PAGE 2 of 2**

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**MEMBER INFORMATION**

| | | |
|---|---|---|
| Member Name: | DOB: | |
| Member ID: | Member weight: | Height: |

**MEDICAL HISTORY (Complete for ALL requests)**

Add questions or options for providing information as needed.

☐ Yes ☐ No

☐ Yes ☐ No

☐ Yes ☐ No

**CURRENT or PREVIOUS THERAPY**

| Medication Name | Strength/ Frequency | Dates of Therapy | Status (Discontinued & Why/Current) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**REAUTHORIZATION**

Add questions as needed

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

**SUPPORTING INFORMATION or CLINICAL RATIONALE**

| |
|---|
| |
| |
| |

| Prescribing Provider Signature | Date |
|---|---|
| | |