HIGHMARK HEALTH OPTIONS

Updated: 04/2022
DMMA Approved: 06/2022

Request for Prior Authorization for Uplizna (Inebilizumab-cdon)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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

Uplizna (Inebilizumab-cdon) Prior Authorization Criteria:

For all requests for Uplizna (Inebilizumab-cdon) all of the following criteria must be met:

- 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 are 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 that required rescue therapy 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 ≤ 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product 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 Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon-Fri 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
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:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a 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: _____

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 a significant improvement with treatment? ☐ Yes ☐ No If **Yes,** please include documentation.

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date