OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Exdensur (depemokimab-ulaa) Prior Authorization Form

***Member Name:*___________________ *Date of Birth:*______________ *Member ID#:*__________________**

Drug Information

❑ **Physician billing (HCPCS code:____________)** ❑ **Pharmacy billing (NDC:_____________________)**

***Dose:*________________ *Regimen:*___________________ *Start Date (or date of next dose):*____________**

Billing Provider Information

***Provider NPI:*____________________________ *Provider Name:*___________________________________**

***Provider Phone:*____________________________ *Provider Fax:*__________________________________**

Prescriber Information

***Prescriber NPI:*_______________________ *Prescriber Name:*_____________________________________**

***Prescriber Phone:*_______________ *Prescriber Fax:*________________ *Specialty*:___________________**

Criteria

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. ***Initial approvals will be for the duration of 1 year.***

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ❑ **Eosinophilic Phenotype Asthma**
   - ❑ **Other: ____________________________**
2. Will Exdensur be used as add-on maintenance treatment for severe eosinophilic phenotype asthma? Yes___ No___
   a. If yes, please indicate member's daily medications and dose prescribed for the treatment of this diagnosis:
   Drug/Dose: ______________________________ Drug/Dose: _________________________________
3. Blood eosinophil count: _________________ Date Determined: _____________________
4. Does member require daily systemic corticosteroids despite compliant use with a medium-to-high dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication? Yes___ No___
   a. If answer is 'no' to previous question, please list number and dates of exacerbations requiring systemic corticosteroids within the last 12 months: Number: _____ Dates: ______________________
5. Please check all that apply:
   - ❑ Member has failed a medium-to-high-dose ICS used compliantly within the last 3-6 consecutive months.
     - Drug/Dose: ____
   - ❑ Member has failed at least 1 other asthma controller medication used in addition to the medium-to-high-dose ICS compliantly for at least the past 3 months.
     - Drug/Dose: ____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit

Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

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DRAFT

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Criteria

For Initial Authorization: *(continued)*

6. Please provide a patient-specific, clinically significant reason (beyond convenience) why the member cannot use Dupixent®, Fasenra®, and Nucala®: ____
____
____
7. Will Exdensur be administered by a health care professional? Yes___ No___
8. Is prescriber an allergist, pulmonologist, or pulmonary specialist? Yes___ No___
   a. If no, has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes___ No___

DRAFT

For Continued Authorization:

1. Is the member compliant with therapy? Yes____ No____
2. Is the member responding well to therapy? Yes____ No____

Additional Information: ____
____
____
____
____

Prescriber Signature:________________________________ Date:___________________________

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Failure to complete this form in full will result in processing delays.*

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University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*