PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Nucala (mepolizumab)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address: Address:	
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?

- ☐ Severe Eosinophilic Asthma
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Is patient a NEW START to Nucala therapy?

☐ Yes ☐ No

Q4. Please indicate location of administration.

- ☐ Home
- ☐ Long Term Care (LTC) facility
- ☐ Physician office (drug from office stock - buy and bill)
- ☐ Physician office (drug from pharmacy with a prescription)

Q5. Specify the prescriber's specialty.

- ☐ Allergist
- ☐ Immunologist

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☐ Pulmonologist
☐ Other (please specify)

Q6. Is the patient 12 years old or older?
☐ Yes ☐ No

Q7. I have provided the most recent chart note, labs, and additional clinical information to support the information provided on this request form.
☐ Yes ☐ No

Q8. For initial request, does the patient have a blood eosinophil concentration of greater than or equal to 150 cells/mcL within the last 6 weeks OR greater than 300 cells/mcL in the past 12 months?
☐ Yes ☐ No

Q9. For initial request, has the patient had 2 or more asthma exacerbations (defined as need for systemic corticosteroids, ER visit or hospitalization) in the last 12 months despite use of the following: greater than or equal to 880 microgram/day of inhaled fluticasone propionate or equivalent for at least 3 months AND at least 1 additional controller medication for at least 3 months?
☐ Yes ☐ No

Q10. For initial request, does patient have chronic use of the following: daily oral glucocorticoids plus an additional inhaled corticosteroid for at least 6 months AND at least 1 additional controller medication for at least 3 months?
☐ Yes ☐ No

Q11. For initial request, will the Nucala dose exceed 100 mg every 4 weeks?
☐ Yes ☐ No

Q12. For initial request, will Nucala be used concomitantly with Cinqair or Xolair?
☐ Yes ☐ No

Q13. For continuation of Nucala, has the patient demonstrated response to therapy? (Select all that apply)
☐ Decreased asthma exacerbation rate
☐ Documented improvement in asthma symptoms
☐ Decreased hospitalizations, emergency department/urgent care visits, or physician visits due to asthma
☐ Decreased requirement for oral corticosteroids

Q14. For continuation of Nucala, does patient have documented compliance with the following: Nucala, inhaled corticosteroid, AND at least 1 additional controller medication?

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☐ Yes ☐ No	
Q15. Additional Comments	

_____ _____

Prescriber Signature Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.