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. Is the patient a new start to therapy?

☐ Yes ☐ No - please specify start date

Q2. For what diagnosis is this drug being prescribed?

☐ Severe Eosinophilic Asthma
☐ Eosinophilic granulomatosis with polyangiitis (EGPA)
☐ Other

Q3. Please provide ICD code(s) for diagnosis.

Q4. Specify the prescriber's specialty.

☐ Allergist
☐ Immunologist
☐ Pulmonologist
☐ Rheumatology
☐ Other (please specify)

Q5. I have provided the most recent chart note, labs, and additional clinical information to support the information

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provided on this request form.

☐ Yes ☐ No

Q6. Will Nucala be used concomitantly with Cinqair, Fasenra, or Xolair?

☐ Yes ☐ No

Q7. For asthma, will the Nucala dose exceed 100 mg every 4 weeks?

☐ Yes ☐ No

Q8. For asthma, 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 asthma, 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 asthma, 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 asthma 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

Q12. For asthma continuation of Nucala, have you provided samples of inhalers to the patient? If yes, please specify which inhaler(s), date, and quantity.

☐ Yes ☐ No

Q13. For EGPA, will the Nucala dose exceed 300 mg every 4 weeks?

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☐ Yes ☐ No

Q14. For EGPA, please select all of the following that the patient has:

☐ Asthma with eosinophilia (blood eosinophil level of 10% or an absolute eosinophil count of more than 1000 cells per cubic millimeter)
☐ Histopathological evidence of eosinophilic vasculitis
☐ Perivascular eosinophilic infiltration or eosinophil-rich granulomatous inflammation
☐ Neuropathy
☐ Pulmonary infiltrates
☐ Sinonasal abnormality
☐ Cardiomyopathy
☐ Glomerulonephritis
☐ Alveolar hemorrhage
☐ Palpable purpura
☐ Positive antineutrophil cytoplasmic antibody (ANCA)

Q15. For EGPA, has the patient experienced relapse while on standard of care therapy, or is the patient refractory to standard therapy (i.e. oral corticosteroid treatment with or without immunosuppressive therapy)

☐ Yes ☐ No

Q16. For EGPA, is the patient currently receiving oral corticosteroid therapy (e.g. prednisolone, prednisone)?

☐ Yes ☐ No

Q17. For EGPA continuation of Nucala, has the patient demonstrated response to therapy? (Select all that apply)

☐ Decreased requirement for oral corticosteroids
☐ Increase in remission time
☐ Decrease in rate of relapses

Q18. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q19. Provide name and NPI of the billing entity

Q20. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be

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submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q21. 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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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