NUCALA (MEPOLIZUMAB) (NON-PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 1/9/2023)

AmeriHealth Caritas Pennsylvania | PerformRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		Specialty:	
State license #:	NPI:	MA Provider ID #	
Street address:	Suite #:	City/state/zip:	
Phone:	Fax:		

CLINICAL INFORMATION

Medication requested: ☐ Nucala 100 mg vial ☐ Nucala _____	Quantity: #_____ vials (100 mg/vial)	Duration requested: _____ months
Dose requested: ☐ 100 mg every 4 weeks ☐ 300 mg every 4 weeks ☐ other: _____		
Diagnosis:		Dx code (required):

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication, if applicable):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

HCPCS (HEALTHCARE COMMON PROCEDURE CODING SYSTEM) INFORMATION (if applicable):

Treatment setting: ☐ Infusion Center ☐ Home ☐ Provider's Office ☐ Hospital Outpatient Facility		
Facility name:	Facility NPI:	
J-code:	Number of units:	Date of service (MM/DD/YYYY):

INITIAL REQUESTS

1.	Is Nucala being prescribed by or in consultation with a specialist?	☐ Yes ☐ No	*Provide specialty:*_____
2.	<u>For a diagnosis of asthma</u>: Is the patient being treated for a diagnosis of asthma that is severe despite use of tolerated asthma controller medications?	☐ Yes ☐ No	*Submit documentation.*
3.	<u>For a diagnosis of asthma</u>: Does the patient have asthma of an eosinophilic phenotype with an absolute blood eosinophil count ≥150/microliter?	☐ Yes ☐ No	Eosinophil count:_____ Date of result:_____
4.	**For a diagnosis of asthma:** Will Nucala be used in addition to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)?	☐ Yes ☐ No	*List medications being used:*_____
5.	<u>For a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)</u>: Does the patient have a history of asthma and absolute blood eosinophil count ≥1,000/microliter or a blood eosinophil level > 10% of leukocytes?	☐ Yes ☐ No	Eosinophil count/level: _____ Date of result:_____
6.	**For a diagnosis of EGPA:** Does the patient have histopathological evidence of the following? (Check all that apply.) ☐ Eosinophilic vasculitis ☐ Perivascular eosinophilic infiltration ☐ Eosinophil-rich granulomatous inflammation		*Submit documentation supporting diagnosis.*
7.	For a diagnosis of EGPA: Does the patient have a documented history of the following? (Check all that apply.) ☐ Neuropathy, mono or poly ☐ Glomerulonephritis ☐ Pulmonary infiltrates, non-fixed ☐ Alveolar hemorrhage ☐ Sino-nasal abnormality ☐ Palpable purpura ☐ Cardiomyopathy ☐ Positive test for ANCA		*Submit documentation supporting diagnosis.*
8.	<u>For a diagnosis of EGPA</u>: Does the patient require systemic glucocorticoids to maintain remission or have an intolerance or contraindication to systemic glucocorticoids?	☐ Yes ☐ No	*Submit documentation.*
9.	<u>For diagnosis of severe EGPA:</u> Does the patient have a history of therapeutic failure of or a contraindication or intolerance to rituximab or cyclophosphamide?	☐ Yes ☐ No	*Yes, list drugs tried:* _____
10.	For a diagnosis of hypereosinophilic syndrome (HES), select all that apply to the patient: ☐ Has documented FIP1L1-PDGFRA–negative HES with organ damage or dysfunction ☐ Has a blood eosinophil count ≥1,000/microliter ☐ Requires or has required systemic glucocorticoids to maintain remission ☐ Has contraindication or intolerance of systemic glucocorticoids		

INITIAL REQUESTS

11. Does the patient have a history of trial and failure of, or contraindication or intolerance to, the preferred Monoclonal Antibodies, Anti-IL, Anti-IgE, Anti-TSLP approved or medically accepted for their condition?
    - ☐ Yes - select all medications tried:
      - ☐ Dupixent
      - ☐ Xolair
      - ☐ Fasenra
    - ☐ No

13. Has the patient been using Nucala in the past 90 days? ☐ Yes ☐ No

RENEWAL REQUESTS

1. Is Nucala being prescribed by or in consultation with a specialist?	☐ Yes	☐ No	*Provide specialty:*_____
2. Did the patient experience measurable evidence of improvement in disease activity and/or severity?	☐ Yes	☐ No	*Submit documentation of patient's response to therapy.*
3. For a diagnosis of HES or EGPA, did the patient have a reduction in use of systemic glucocorticoids?	☐ Yes	☐ No	
4. For a diagnosis of asthma, will Nucala continue to be used in addition to standard asthma controller medications (e.g., inhaled corticosteroids, inhaled LABAs, etc.)?	☐ Yes	☐ No	*List medications being used:*_____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: