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Nucala (Mepolizumab) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
<u>Nonpreferred</u> ☐ Nucala auto-injector ☐ Nucala prefilled syringe	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for mepolizumab (Nucala). Requests will not be considered with concurrent use of omalizumab. Payment will be considered under the following conditions: 1) Patient meets the FDA approved age; and 2) Patient has a diagnosis of severe asthma with an eosinophilic phenotype; and 3) Patient has a pretreatment blood eosinophil count of ≥150 cells per mcL within the previous 6 weeks or blood eosinophils of ≥300 cells per mcL within 12 months prior to initiation of therapy; and 4) Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and 5) Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and 6) A pretreatment forced expiratory volume in 1 second (FEV1) <80% predicted; and 7) Prescriber is an allergist, immunologist, or pulmonologist.

If the criteria for coverage are met, an initial authorization will be given for 3 months to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if

one or more of the following criteria are met: 1) Patient continues to receive therapy with an ICS, LABA and LTRA; and 2) Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or 3) Patient has experienced a decrease in administration of rescue medication (albuterol); or 4) Patient has experienced a decrease in exacerbation frequency; or 5) Patient has experienced an increase in predicted FEV1 from the pretreatment baseline. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Pretreatment blood eosinophil count (attach lab): _____ Date Obtained: _____
OR
Blood eosinophil count obtained within 12 months prior to initiation of treatment (attach lab): _____
Date Obtained: _____

Pretreatment baseline ppFEV1: _____ Date Obtained: _____

Document current use of:
High-dose inhaled corticosteroid: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start date: _____

Long-acting beta2-agonist: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start date: _____

Leukotriene receptor antagonist: Drug Name: _____ Strength: _____
Dosing Instructions: _____ Trial start date: _____

Does patient have a history of 2 or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA? ☐ No ☐ Yes (provide dates): _____

Prescriber's specialty: ☐ Allergist ☐ Immunologist ☐ Pulmonologist ☐ Other: _____

Will the patient be taking omalizumab in combination with mepolizumab? ☐ No ☐ Yes

For renewals only:
Does patient continue to receive therapy with an ICS, LABA and LTRA? ☐ No ☐ Yes

Please indicate if the patient has experienced any of the following (check all that apply):
☐ Reduction in asthma signs and symptoms including:

- Wheezing
- Chest tightness
- Coughing
- Shortness of breath

☐ Decrease in administration of rescue medications (albuterol)
☐ Decrease in exacerbation frequency
☐ Increase in ppFEV$_1$ from the pretreatment baseline Current ppFEV$_1$: _____ Date Obtained: _____
Please describe: _____
_____
Medical or contraindication reason to override trial requirements: _____
_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.