Nucala (mepolizumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA. ☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
☐ Eosinophilic granulomatosis with polyangiitis(EGPA) ☐ Eosinophilic phenotype asthma ☐ Hypereosinophilic syndrome(HES) ☐ Chronic rhinisinusitis with nasal polyps ☐ Other diagnosis: _____ICD-10 Code(s): _____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:

Will patient use Nucala(mepolizumab) in combination with Fasenra(benralizumab) or Dupixent(dupilumab) or Xolair(omalizmab)? ☐ Yes ☐ No

Is prescriber an allergist, pulmonologist or immunologist? ☐ Yes ☐ No

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<u>Eosinophilic granulomatosis with polyangiitis(EGPA):</u>

Has the patient had EGPA for at least 6months? ☐ Yes ☐ No

Has the patient been on a stable dose of presnisolone or prednisone of greater than or equal to 7.5mg to greater than or equal to 50mg/day for at least 4 weeks before starting Nucala? ☐ Yes ☐ No

Does the patient have relapsing or refractory disease despite systemic corticosteroids and or immunosuppressive therapy? ☐ Yes ☐ No

Does patient have a history or presence of asthma? ☐ Yes ☐ No

Does the patient have a blood eosinophil level of 10% ? ☐ Yes ☐ No Please submit lab report.

Does the patient have an absolute eosinophil count of more than 1000cells per cubic millimeter? ☐ Yes ☐ No Please submit lab report.

Does the patient have any of the below? ☐ Yes ☐ No

Please mark and submit chart notes and /or lab report(s).

- ☐ **Histo-pathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation**

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

- □ **Neuropathy**
- □ **Pulmonary infiltrates**
- □ **Sino-nasal abnormality**
- □ **Cardiomyopathy**
- □ **Glomerulonephritis**
- □ **Alveolar hemorrhage**
- □ **Palpable purpura**
- □ **Antineutrophil cytoplasmic antibody(ANCA) positivity**

<u>Eosinophilic phenotype asthma:</u>

Has patient had at least 2 asthma exacerbations in the past 2 years warranting initiation of systemic glucocorticoids(or an increase to the patient's baseline dose of systemic glucocorticoids) prior to using Nucala ? □ **Yes** □ **No**

Has the patient had at least one blood eosinophil count of at least 150 cells per microliter? □ **Yes** □ **No**
Please submit lab documentation.

For adults (18years of age and older), does the patient have an FEV_1 equaling less than 80% of the predicted volume? □ **Yes** □ **No** **Please submit chart notes/PFT report**

For adolescents (age 12-17years), does the patient have an FEV_1 equaling less than 90% of the predicted volume or a ratio of the FEV_1 to the forced vital capacity(FVC) equaling less than 0.8? □ **Yes** □ **No**
Please submit chart notes/PFT report

Is the patient a current or former smoker? □ **Yes** □ **No**

<u>Hypereosinophilic Syndrome(HES):</u>

Within the past 12 months, has the patient has had two or more episodes of HES-related flares (worsening of clinical symptoms and/or worsening of blood eosinophil counts) requiring escalation of therapy? □ **Yes** □ **No**
***Please submit chart documentation*.**

In the past 12 months, did any of the patient's HES-related flares occur spontaneously (in other words, did NOT occur within 4 weeks of a decrease in therapy)? □ **Yes** □ **No** ***Please submit chart documentation.***

Within the past 4 weeks prior to starting Nucala, is the patient's blood eosinophil count equaling 1000cells/microliter or greater? □ **Yes** □ **No** ***Please submit lab report*.**

Has the patient been on a stable dose of HES therapy for the past month (such as oral corticosteroids, immunosuppressive agents and/or cytotoxic therapy)? □ **Yes** □ **No** ***Please submit chart documentation.***

<u>Chronic Rhinosinusitis with Nasal Polyps(CRSwNP):</u>

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Has patient had at least one polypectomy(physical removal of a nasal polyp) in the past 10 years? □ **Yes** □ **No**
Please submit chart documentation.

Has patient been treated with a nasal steroid for the past 8 weeks? □ **Yes** □ **No** ***Please submit chart documentation.***

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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