



# Nucala(mepolizumab) Prior Authorization Request Form



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

**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](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:
<input type="checkbox"/> NEW THERAPY		<input type="checkbox"/> RENEWAL	
DURATION OF THERAPY (SPECIFIC DATES):		IF RENEWAL: DATE THERAPY INITIATED:	

*Continued on next page*





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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

**1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?**  YES (if yes, complete below)  NO

<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>	<b>DURATION OF THERAPY (SPECIFY DATES):</b>	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>

**2. LIST DIAGNOSES:** **ICD-10:**

<input type="checkbox"/> Eosinophilic granulomatosis with polyangiitis(EGPA) <input type="checkbox"/> Eosinophilic phenotype asthma <input type="checkbox"/> Hypereosinophilic syndrome(HES) <input type="checkbox"/> Chronic rhinisinusitis with nasal polyps <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
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**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 Fasenna(benralizumab) or Dupixent(dupilumab) or Xolair(omalizumab)?  Yes  No

**Eosinophilic granulomatosis with polyangiitis(EGPA):**

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

Has the patient been on a stable dose of prednisolone 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
- Neuropathy
- Pulmonary infiltrates
- Sino-nasal abnormality
- Cardiomyopathy
- Glomerulonephritis





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- Alveolar hemorrhage
- Palpable purpura
- Antineutrophil cytoplasmic antibody(ANCA) positivity

**Eosinophilic phenotype asthma:**

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 (18 years of age and older), does the patient have an FEV<sub>1</sub> equaling less than 80% of the predicted volume?  Yes  No Please submit chart notes/PFT report

For adolescents (age 12-17 years), does the patient have an FEV<sub>1</sub> equaling less than 90% of the predicted volume or a ratio of the FEV<sub>1</sub> 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

**Hypereosinophilic Syndrome(HES):**

Is prescriber an allergist or immunologist?  Yes  No

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 1000 cells/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.

**Chronic Rhinosinusitis with Nasal Polyps(CRSwNP):**

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





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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:** \_\_\_\_\_

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**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

