NUCALA (MEPOLIZUMAB) (PREFERRED) PRIOR AUTHORIZATION FORM

(form effective 7/30/20)

Keystone First | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

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. Will the patient be monitored and/or treated for helminth infection as recommended in package labeling?	☐ Yes ☐ No	
3. <u>For a patient ≥ 50 years of age:</u> Did the patient receive the varicella-zoster vaccine (Shingrix/Zostavax) at least 4 weeks prior to initiation of Nucala?	☐ Yes ☐ No	*Submit documentation.*
4. <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.*
5. <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:_____
6. For a diagnosis of asthma: Is the patient currently receiving optimally titrated doses, or have a contraindication or intolerance to, any of the following? ☐ inhaled glucocorticoid ☐ leukotriene modifier ☐ long-acting beta-agonist (LABA) ☐ other (e.g., tiotropium, theophylline): _____	☐ Yes ☐ No	Submit documentation of medication regimen and response to treatment.
7. <u>For a diagnosis of EGPA</u>: Does the patient have a history of asthma and absolute blood eosinophil count ≥ 1000/microliter or a blood eosinophil level > 10% of leukocytes?	☐ Yes ☐ No	Eosinophil count/level: _____ Date of result:_____
8. <u>For a diagnosis of EGPA</u>: Is the patient's diagnosis of EGPA consistent with medically accepted diagnostic criteria, such as American College of Rheumatology or Lanham criteria?	☐ Yes ☐ No	*Submit documentation supporting diagnosis.*
9. <u>For a diagnosis of EGPA</u>: Does the patient have a history of therapeutic failure of ≥ 3 months of prednisolone ≥ 7.5 mg/day (or equivalent), or have an intolerance or contraindication to systemic corticosteroids?	☐ Yes ☐ No	*Submit documentation.*

RENEWAL REQUESTS

1. Did the patient experience measurable evidence of improvement in disease activity and/or severity?	☐ Yes ☐ No	*Submit documentation of patient's response to therapy.*
2. Will the patient be monitored and/or treated for helminth infection as recommended in package labeling?	☐ Yes ☐ No	

RATIONALE FOR HOSPITAL OUTPATIENT FACILITY TREATMENT SETTING (if applicable):

☐ Documented history of severe adverse reaction occurred during or immediately following an infusion and/or the adverse reaction did not respond to conventional interventions

☐ Documentation that the member is medically unstable for the safe and effective administration of the prescribed medication at an alternative site of care as a result of one of the following:
- ☐ Complex medical condition, status, or therapy requires services beyond the capabilities of an office or home infusion setting (clinical instability or a complex regimen that requires frequent clinical assessment or monitoring, which would be beyond the capabilities of an office or home infusion setting)
- ☐ Documented history of medical instability, significant comorbidity, or concerns regarding fluid status inhibits treatment at a less intensive site of care (unstable fluid status associated with heart failure or advanced [stage 4 or 5] renal failure)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: