maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Nucala

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Will Nucala be used in combination with another anti-interleukin (IL) monoclonal antibody (for example, Cinqair, Dupixent, Fasenra) or Xolair? [If yes, no further questions.]	Yes	No
2	Is the patient currently receiving Nucala? [If no, skip to question 9.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan?	Yes	No

If you have any questions, call:
1-888-258-8250

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[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]
[If no, skip to question 8.]

5 What is the diagnosis or indication?
[] Asthma (If checked, go to 6)

[] Chronic rhinosinusitis with nasal polyposis (CRSwnP) (If checked, go to 6)

[] Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome] (If checked, go to 6)

[] Hypereosinophilic syndrome (If checked, go to 6)

[] Atopic dermatitis (If checked, no further questions)

[] Eosinophilic esophagitis, eosinophilic gastroenteritis, or eosinophilic colitis (If checked, no further questions)

[] Chronic Obstructive Pulmonary Disease (COPD) (If checked, no further questions)

[] Other (If checked, no further questions)

6 Has the patient been on established therapy for at least 3 months? Yes No
[If no, skip to question 9.]

7 Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. Yes No
[No further questions.]

8 Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. Yes No
[If yes, skip to question 9.]
[If no, no further questions.]

9 What is the diagnosis or indication?
[] Asthma (If checked, go to 10)

[] Chronic rhinosinusitis with nasal polyposis (CRSwnP) (If checked, go to 37)

[] Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome] (If checked, go to 22)

[] Hypereosinophilic syndrome (If checked, go to 29)

[] Atopic dermatitis (If checked, no further questions)

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	[] Eosinophilic esophagitis, eosinophilic gastroenteritis, or eosinophilic colitis (If checked, no further questions) [] Chronic Obstructive Pulmonary Disease (COPD) (If checked, no further questions) [] Other (If checked, no further questions)		
10	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
11	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [If no, no further questions.]	Yes	No
12	Does the patient have a blood eosinophil level of 150 cells/microliter or greater within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin-5 therapy? [Note: Examples of anti-interleukin-5 therapies include Fasenra, Nucala, Cinqair.] [If no, no further questions.]	Yes	No
13	Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following: A) An inhaled corticosteroid AND B) At least one additional asthma controller/maintenance medication? [Note: Examples of additional asthma controller/maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, and theophylline.] [Note: Use of a combination inhaler containing both an inhaled corticosteroid and a long-acting beta2-agonist would fulfil the requirement.] [If no, no further questions.]	Yes	No
14	Is the requested medication being used in combination with an inhaled corticosteroid (ICS) OR inhaled corticosteroid- containing combination inhaler? [If no, no further questions.]	Yes	No
15	Does the patient have asthma that is uncontrolled as defined by two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? [If yes, skip to question 20.]	Yes	No
16	Does the patient have asthma that is uncontrolled as defined by one asthma exacerbation requiring hospitalization in the previous year? [If yes, skip to question 20.]	Yes	No
17	Does the patient have asthma that is uncontrolled as defined by a forced expiratory volume in 1 second (FEV1) less than 80% predicted? [If yes, skip to question 20.]	Yes	No
18	Does the patient have an FEV1/forced vital capacity (FVC) less than 0.80?	Yes	No

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	[If yes, skip to question 20.]		
19	Does the patient have asthma that is uncontrolled as defined by asthma that worsens upon tapering of oral corticosteroid therapy? [If no, no further questions.]	Yes	No
20	Does the requested dose exceed the FDA approved label dosing for the indication? [If yes, no further questions.]	Yes	No
21	Will the requested medication be used in combination with other monoclonal antibodies used to treat asthma? [Note: Examples of monoclonal antibody therapies include benralizumab, mepolizumab and dupilumab.] [No further questions.]	Yes	No
22	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
23	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, pulmonologist or a rheumatologist? [If no, no further questions.]	Yes	No
24	Has the patient tried a minimum of 4 weeks of therapy with a corticosteroid (for example, prednisone)? [If no, no further questions.]	Yes	No
25	Does the patient have/or had a blood eosinophil level of 150 cells/microliter or greater within the previous 6 weeks or within 6 weeks prior to treatment with any anti-interleukin (IL)-5 therapy? [Note: Examples of anti-interleukin-5 therapies include Nucala, Cinqair, and Fasenra.] [If no, no further questions.]	Yes	No
26	Will the requested medication be used in combination with other monoclonal antibodies? [Note: Examples of monoclonal antibody therapies include benralizumab, mepolizumab and dupilumab.] [If yes, no further questions.]	Yes	No
27	Does the requested dose exceed the FDA approved label dosing for the indication? [If yes, no further questions.]	Yes	No
28	Does the patient have active, non-severe disease? [Note: Non-severe disease is defined as vasculitis without life- or organ-threatening manifestations and examples of symptoms in patients with non-severe disease include rhinosinusitis, asthma, mild systemic symptoms, uncomplicated	Yes	No

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	cutaneous disease and mild inflammatory arthritis.] [No further questions.]		
29	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
30	Has the patient had hypereosinophilic syndrome for at least 6 months? [If no, no further questions.]	Yes	No
31	Does the patient have FIP1L1-PDGFRalpha-negative disease? [If no, no further questions.]	Yes	No
32	Does the patient have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome, according to the prescriber? [Note: Examples of secondary causes of hypereosinophilic syndrome include drug hypersensitivity, parasitic helminth infection, human immunodeficiency virus infection, non-hematologic malignancy.] [If yes, no further questions.]	Yes	No
33	Prior to initiating therapy with any anti-interleukin-5 therapy, did/does the patient have a blood eosinophil level of at least 1,000 cells per microliter? [Note: Examples of anti-interleukin-5 therapies include Nucala, Cinqair, and Fasenra.] [If no, no further questions.]	Yes	No
34	Has the patient tried at least ONE other treatment for hypereosinophilic syndrome for a minimum of 4 weeks? [Note: Treatments for hypereosinophilic syndrome include systemic corticosteroids, hydroxyurea, cyclosporine, imatinib, methotrexate, tacrolimus, and azathioprine.] [If no, no further questions.]	Yes	No
35	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist? [If no, no further questions.]	Yes	No
36	Does the requested dose exceed the FDA approved label dosing for the indication? [No further questions.]	Yes	No
37	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
38	Does the patient have chronic rhinosinusitis with nasal polyposis as evidenced by direct examination, endoscopy, or sinus computed tomography (CT) scan? [If no, no further questions.]	Yes	No
39	Has the patient experienced TWO or more of the following symptoms for at least 6	Yes	No

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	months: nasal congestion, nasal obstruction, nasal discharge, and/or reduction/loss of smell? [If no, no further questions.]		
40	Has the patient received at least 3 months of therapy with an intranasal corticosteroid? [If no, no further questions.]	Yes	No
41	Will the patient continue to receive therapy with an intranasal corticosteroid while on the requested medication? [If no, no further questions.]	Yes	No
42	Does the requested dose exceed the FDA approved label dosing for the indication? [If yes, no further questions.]	Yes	No
43	Is the requested medication prescribed by or in consultation with an allergist, immunologist, or an otolaryngologist (ear, nose and throat [ENT] physician specialist)? [If no, no further questions.]	Yes	No
44	Has the patient received at least ONE course of treatment with a systemic corticosteroid for 5 days or more within the previous 2 years? [If yes, no further questions.]	Yes	No
45	Does the patient have a contraindication to systemic corticosteroid therapy? [If yes, no further questions.]	Yes	No
46	Has the patient had prior surgery for nasal polyps?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

If you have any questions, call: 1-888-258-8250

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Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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