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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for initial therapy or for a continuation of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Will the requested medication be used in combination with other monoclonal antibodies? [Note: Examples of monoclonal antibody therapies include benralizumab,	Yes	No

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	mepolizumab and dupilumab.] [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [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.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	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
9	What is the diagnosis or indication?		

[] Asthma (If checked, go to 10)

[] Eosinophilic granulomatosis with polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome] (If checked, go to 21)

[] Hypereosinophilic syndrome (If checked, go to 27)

[] Chronic rhinosinusitis with nasal polyposis (CRSwnP) (If checked, go to 35)

[] Chronic obstructive pulmonary disease (COPD) with an eosinophilic phenotype (If checked, go to 45)

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

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

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	[] Other (If checked, no further questions)		
10	Is the patient 6 years of age or older? [If no, no further questions.]	Yes	No
11	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, and Cinqair.] [If no, no further questions.]	Yes	No
12	Has the patient received at least 3 consecutive months of combination therapy with BOTH of the following: A) An inhaled corticosteroid (ICS) AND B) At least one additional asthma controller/maintenance medication? [Note: Examples of additional asthma controller/maintenance medications are inhaled long-acting beta2-agonists [LABA], inhaled long-acting muscarinic antagonists [LAMA], leukotriene receptor antagonists [LTRA], and theophylline. Use of a combination inhaler containing both an inhaled corticosteroid [ICS] and a long-acting beta2-agonist [LABA] would fulfill the requirement.] [If no, no further questions.]	Yes	No
13	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
14	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 19.]	Yes	No
15	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 19.]	Yes	No
16	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 19.]	Yes	No
17	Does the patient have a forced expiratory volume in 1 second /forced vital capacity (FEV1/FVC) less than 0.80? [If yes, skip to question 19.]	Yes	No
18	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
19	Is the requested medication being prescribed by or in consultation with an	Yes	No

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	allergist, immunologist, or pulmonologist? [If no, no further questions.]		
20	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [No further questions.]	Yes	No
21	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
22	Has the patient tried a minimum of 4 weeks of therapy with a corticosteroid (for example, prednisone)? [If no, no further questions.]	Yes	No
23	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
24	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 cutaneous disease and mild inflammatory arthritis.] [If no, no further questions.]	Yes	No
25	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
26	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [No further questions.]	Yes	No
27	Is the patient 12 years of age or older? [If no, no further questions.]	Yes	No
28	Has the patient had hypereosinophilic syndrome for at least 6 months? [If no, no further questions.]	Yes	No
29	Does the patient have FIP1L1-PDGFRalpha-negative disease? [If no, no further questions.]	Yes	No
30	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	Yes	No

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	hypersensitivity, parasitic helminth infection, human immunodeficiency virus infection, and non-hematologic malignancy.] [If yes, no further questions.]		
31	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
32	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
33	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist? [If no, no further questions.]	Yes	No
34	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [No further questions.]	Yes	No
35	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
36	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
37	Has the patient experienced TWO or more of the following symptoms for at least 6 months: A) Nasal congestion, B) Nasal obstruction, C) Nasal discharge, C) Reduction/loss of smell? [If no, no further questions.]	Yes	No
38	Has the patient received at least 3 months of therapy with an intranasal corticosteroid? [If no, no further questions.]	Yes	No
39	Will the patient continue to receive therapy with an intranasal corticosteroid while on the requested medication? [If no, no further questions.]	Yes	No
40	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, skip to question 43.]	Yes	No

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41	Does the patient have a contraindication to systemic corticosteroid therapy? [If yes, skip to question 43.]	Yes	No
42	Has the patient had prior surgery for nasal polyps? [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	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [No further questions.]	Yes	No
45	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
46	Does the patient have a diagnosis of chronic obstructive pulmonary disease (COPD) with moderate to severe airflow limitation (post-bronchodilator forced expiratory volume in 1 second /forced vital capacity [FEV1/FVC] ratio less than 0.7 and post-bronchodilator FEV1 of 20% to 80% predicted)? [If no, no further questions.]	Yes	No
47	Has the patient's chronic obstructive pulmonary disease (COPD) remained inadequately controlled despite adherence to optimized inhaled maintenance therapy, including triple therapy with inhaled corticosteroids (ICS), long-acting beta agonists (LABA), and long-acting muscarinic antagonists (LAMA)? [If no, no further questions.]	Yes	No
48	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, and Cinqair.] [If no, no further questions.]	Yes	No
49	Has the patient experienced at least two moderate or one severe chronic obstructive pulmonary disease (COPD) exacerbation(s) (requiring systemic corticosteroids, emergency department visit, or hospitalization) in the past 12 months despite optimized inhaled therapy? [If no, no further questions.]	Yes	No
50	Will the requested medication be used in addition to inhaled maintenance therapy used in treatment of chronic obstructive pulmonary disease (COPD)? [If no, no further questions.]	Yes	No

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51	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or pulmonologist? [If no, no further questions.]	Yes	No
52	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 100 mg every 4 weeks.]	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

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