HEALTHY U CHIP

# PRIOR AUTHORIZATION REQUEST FORM
## NUCALA®

**For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department.**

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- For **Retail Pharmacy** please fax requests to: 385-425-4052

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

| | | |
|---|---|---|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |
| Height/Weight: | | HCPCS Code: |

***Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.***

**Product being request**: ☐ Nucala® (mepolizumab)

Dosing/Frequency:_____

**Note:** for the treatment of nasal polyps see Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

**If the request is for reauthorization, proceed to reauthorization section**

| Questions | Yes | No | Comments/Notes |
|---|---|---|---|
| **EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)** | | | |
| 1. Is the request made by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist? | ☐ | ☐ | |
| 2. Does the member have a past medical history or presence of asthma? | ☐ | ☐ | **Please provide documentation** |
| 3. Does documentation show blood eosinophil level of ≥10% or an absolute count >1000cells/$mm^3$? | ☐ | ☐ | **Please provide documentation** |
| 4. Does the member have a confirmed diagnosis of EGPA with at least 2 of the following:<br>• Neuropathy<br>• Pulmonary infiltrates<br>• Sinonasal abnormality<br>• Cardiomyopathy<br>• Glomerulonephritis<br>• Alveolar hemorrhage<br>• Palpable purpura<br>• Antineutrophil cytoplasmic antibody (ANCA) positivity<br>• Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration or eosinophil rich granulomatous inflammation | ☐ | ☐ | **Please provide documentation** |

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| 5. Has the member been on a stable corticosteroid dose for at least 4 weeks prior to Nucala® therapy initiation? | ☐ | ☐ | **Please provide documentation** |
| 6. Has the member had a trial and failure of at least one of the following immunosuppressants used for maintenance therapy: azathioprine, methotrexate, or leflunomide? | ☐ | ☐ | **Please provide documentation** |
| 7. Does documentation show objective baseline severity (e.g. nighttime awakenings, daytime symptoms, FEV1, etc.)? | ☐ | ☐ | **Please provide documentation** |
| **HYPEREOSINOPHILIC SYNDROME** | | | |
| 1. Has the member had a diagnosis of hypereosinophilic syndrome for at least 6 months without an identifiable non-hematologic secondary cause? | ☐ | ☐ | **Please provide documentation** |
| 2. Does documentation show the member is negative for platelet-derived growth factor receptor alpha (*PDGFRA*) and FIP1L1? | ☐ | ☐ | **Please provide documentation** |
| 3. Has the member been on a stable dose of oral corticosteroids, immunosuppressants, or cytotoxic therapy such as hydroxyurea or methotrexate for at least 4 months prior to Nucala® therapy initiation? | ☐ | ☐ | **Please provide documentation** |
| 4. Does the member have a blood eosinophil count > 1,500 eosinophils/µL on 2 examinations at least 1 month apart and/or presence of tissue eosinophilia? | ☐ | ☐ | **Please provide documentation** |
| 5. Have other causes of elevated eosinophils and/or organ damage been ruled out? | ☐ | ☐ | **Please provide documentation** |
| **NUCALA FOR ASTHMA** | | | |
| 1. Does the member have a confirmed diagnosis of eosinophilic asthma? | ☐ | ☐ | |
| 2. Has the member tried and failed or have a contraindication or intolerance to the preferred product Fasenra® (benralizumab)? | ☐ | ☐ | |
| 3. Does documentation show the member's baseline eosinophil count? | ☐ | ☐ | **Please provide documentation** |
| 4. Is the request made by an asthma specialist, allergist, immunologist, or pulmonologist? | ☐ | ☐ | |
| 5. Has the member been at least 80% compliant with a high-dose inhaled corticosteroid (ICS)/long-acting inhaled beta-2-agonist (LABA) inhaler for at least the past 6 months? | ☐ | ☐ | **Please provide documentation** |
| 6. Does the member have poor asthma control, defined as two or more acute exacerbations in the past 12 months requiring additional medical treatment? | ☐ | ☐ | **Please provide documentation** |
| 7. Does documentation show the member's forced expiratory volume (FEV1) is < 80%? | ☐ | ☐ | **Please provide documentation** |
| 8. Are underlying conditions or triggers for asthma or pulmonary disease maximally managed? | ☐ | ☐ | |
| 9. Is the member an active smoker?<br>If yes, does documentation show that smoking cessation has been addressed? | ☐ | ☐ | **Please provide documentation** |
| **REAUTHORIZATION** | | | |
| **For EGPA:** | | | |
| 1. Is the request for reauthorization of therapy? | ☐ | ☐ | |
| 2. Does updated documentation show that the member has experienced a positive clinical response of at least one of the following:<br>• reduction in the frequency and/or severity of relapses | ☐ | ☐ | **Please provide documentation** |

| | | | |
|---|---|---|---|
| • reduction or discontinuation of doses of corticosteroids and/or immunosuppressants<br>• disease remission<br>• reduction in severity or frequency of EGPA-related symptoms | | | |
| For **Hypereosinophilic Syndrome** | | | |
| 1. Is the request for reauthorization of therapy? | ☐ | ☐ | |
| 2. Does documentation show a positive response to therapy evidenced by a reduction in frequency of HES flares? | ☐ | ☐ | **Please provide documentation** |
| For **Asthma** | | | |
| Is the request for reauthorization? | ☐ | ☐ | |
| Does updated documentation show sustained clinical improvement from baseline, such as decreased nighttime awakenings, improved FEV1, reduced missed days from work/school, decreased daytime symptoms, etc.? | ☐ | ☐ | **Please provide documentation** |
| **What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.** | | | |
| Additional information: | | | |
| Physician's Signature: | | | |

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Policy: PHARM-CHIP-144
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024