

# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### NUCALA®

**For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.**

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- 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 assistance: 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
<b>EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)</b>			
1. Is the request made by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a past medical history or presence of asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show blood eosinophil level of $\geq 10\%$ or an absolute count $> 1000 \text{ cells/mm}^3$ ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a confirmed diagnosis of EGPA with at least 2 of the following: <ul style="list-style-type: none"> <li>• Neuropathy</li> <li>• Pulmonary infiltrates</li> <li>• Sinonasal abnormality</li> <li>• Cardiomyopathy</li> <li>• Glomerulonephritis</li> <li>• Alveolar hemorrhage</li> <li>• Palpable purpura</li> <li>• Antineutrophil cytoplasmic antibody (ANCA) positivity</li> <li>• Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration or eosinophil rich granulomatous inflammation</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

5. Has the member been on a stable corticosteroid dose for at least 4 weeks prior to Nucala® therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation show objective baseline severity (e.g. nighttime awakenings, daytime symptoms, FEV1, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>HYPEREOSINOPHILIC SYNDROME</b>			
1. Has the member had a diagnosis of hypereosinophilic syndrome for at least 6 months without an identifiable non-hematologic secondary cause?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show the member is negative for platelet-derived growth factor receptor alpha ( <i>PDGFRA</i> ) and FIP1L1?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Have other causes of elevated eosinophils and/or organ damage been ruled out?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>NUCALA FOR ASTHMA</b>			
1. Does the member have a confirmed diagnosis of eosinophilic asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member tried and failed or have a contraindication or intolerance to the preferred product Fasentra® (benralizumab)?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show the member's baseline eosinophil count?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the request made by an asthma specialist, allergist, immunologist, or pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have poor asthma control, defined as two or more acute exacerbations in the past 12 months requiring additional medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation show the member's forced expiratory volume (FEV1) is < 80%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Are underlying conditions or triggers for asthma or pulmonary disease maximally managed?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Is the member an active smoker? If yes, does documentation show that smoking cessation has been addressed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
<b>For EGPA:</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show that the member has experienced a positive clinical response of at least one of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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<ul style="list-style-type: none"> <li>• reduction in the frequency and/or severity of relapses</li> <li>• reduction or discontinuation of doses of corticosteroids and/or immunosuppressants</li> <li>• disease remission</li> <li>• reduction in severity or frequency of EGPA-related symptoms</li> </ul>			
<b>For Hypereosinophilic Syndrome</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a positive response to therapy evidenced by a reduction in frequency of HES flares?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>For Asthma</b>			
Is the request for reauthorization?	<input type="checkbox"/>	<input type="checkbox"/>	
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.?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician's Signature:			

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

Policy: PHARM-HCU-144  
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