

**NUCALA (mepolizumab) PRIOR AUTHORIZATION FORM**

- Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines and quantity limits may be found in the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Nucala accessible on the Department’s Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	
<input type="checkbox"/> Renewal request	PA# _____	Prescriber name: _____	
Name of office contact: _____		Specialty: _____	
Contact’s phone number: _____		State license #: _____	
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

**CLINICAL INFORMATION**

<b>Medication requested:</b>	<input type="checkbox"/> Nucala 100 mg vial	<b>Dose requested:</b>	<input type="checkbox"/> 1 dose (1 vial) SQ every 4 weeks	<input type="checkbox"/> other: _____
<b>Quantity requested:</b>	<input type="checkbox"/> # _____ vials (100 mg/vial)	<b>Duration requested:</b>	_____ months	
<b>Diagnosis:</b>			<b>Dx code (required):</b>	

**INITIAL REQUESTS**

1. Check all options that apply to the Recipient and submit documentation for each, including chart notes, test results, and medication history.

diagnosis of asthma that is confirmed by ALL of the following:

- medical history & physical exam findings
- spirometry results that demonstrate obstruction
- reversibility demonstrated by either an increase in FEV<sub>1</sub> of ≥ 12% from baseline OR an increase of ≥ 10% of predicted FEV<sub>1</sub>

asthma is an eosinophilic phenotype with absolute blood eosinophil count ≥ 150/microliter

trial & failure, contraindication, or intolerance of maximal therapeutic doses of asthma controller medications

asthma is graded as severe despite use of tolerated doses of asthma controller medications confirmed by 1 or more of the following:

- asthma symptoms that occur throughout the day, such as coughing, wheezing, and dyspnea
- use of a rescue inhaler, such as a beta-2 agonist (i.e., albuterol, levalbuterol), several times per day
- ≥ 2 asthma exacerbations per year that require the use of oral systemic corticosteroids
- often experiences 7 nighttime awakenings per week
- FEV<sub>1</sub> < 60%
- FEV<sub>1</sub>/FVC reduced > 5%

2. Is the Recipient at increased risk for, or have signs/symptoms of, a parasitic (helminthic) infection?

Yes – submit documentation

No

3. For Recipients ≥ 50 years of age, has the Recipient received the varicella-zoster vaccine (i.e., shingles vaccine/Zostavax) at least 4 weeks prior to initiation of Nucala?

Yes – submit documentation of vaccination administration.

No – submit documentation explaining why the Recipient has not received the vaccine, such a contraindication to the vaccine

**RENEWAL REQUESTS**

1. Has the Recipient experienced measurable evidence of improvement in asthma severity?

Yes Submit documentation of Recipient’s response to therapy.

No

2. Is the Recipient at increased risk for, or have signs/symptoms of, a parasitic (helminthic) infection?

Yes – submit documentation

No

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b> _____	<b>Date:</b> _____
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