pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

NUCALA (mepolizumab) (preferred) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Monoclonal Antibodies (MABs), Anti-IL, Anti-IgE** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Nucala 100 mg vial ☐Nucala _____	**Quantity:** #_____ vials (100 mg/vial)	**Duration requested:** _____ months
Dose requested: ☐100 mg every 4 weeks	☐300 mg every 4 weeks	☐other: _____
Diagnosis:	**Dx code (*required*):**	
Specialty Pharmacy Drug Program: Which specialty pharmacy will be used?	☐Diplomat Specialty	☐Walgreens Specialty

Initial requests		
1. Is Nucala being prescribed by or in consultation with a specialist?	☐Yes ☐No	*Submit documentation of consultation, if applicable.*
2. Will the beneficiary be monitored and/or treated for helminth infection as recommended in package labeling?	☐Yes	☐No
3. ***For a beneficiary ≥ 50 years of age:*** Did the beneficiary receive the varicella-zoster vaccine (Shingrix/Zostavax) at least 4 weeks prior to initiation of Nucala?	☐Yes ☐No	*Submit documentation.*
4. ***For a diagnosis of asthma:*** Is the beneficiary being treated for a diagnosis of asthma that is severe despite use of tolerated asthma controller medications?	☐Yes ☐No	*Submit documentation.*
5. ***For a diagnosis of asthma:*** Does the beneficiary have asthma of an eosinophilic phenotype with an absolute blood eosinophil count ≥ 150/microliter?	☐Yes ☐No	*Submit documentation of lab results.*
6. ***For a diagnosis of asthma:*** Is the beneficiary currently receiving optimally titrated doses, or have a contraindication or intolerance to, any of the following? ☐inhaled glucocorticoid ☐long-acting beta-agonist (LABA) ☐leukotriene modifier ☐other (eg, tiotropium, theophylline): _____	☐Yes ☐No	*Submit documentation of medication regimen and response to treatment.*
7. ***For a diagnosis of EGPA:*** Does the beneficiary have a history of asthma and absolute blood eosinophil count ≥ 1000/microliter or a blood eosinophil level > 10% of leukocytes?	☐Yes ☐No	*Submit documentation, including test results.*
8. ***For a diagnosis of EGPA:*** Is the beneficiary's diagnosis of EGPA consistent with medically accepted diagnostic criteria, such as American College of Rheumatology or Lanham criteria?	☐Yes ☐No	*Submit documentation supporting diagnosis.*
9. ***For a diagnosis of EGPA:*** Does the beneficiary have a history of therapeutic failure of ≥ 3 months of prednisolone ≥ 7.5 mg/day (or equivalent), or have an intolerance or contraindication to systemic corticosteroids?	☐Yes ☐No	*Submit documentation.*
Renewal requests		
1. Did the beneficiary experience measurable evidence of improvement in disease activity and/or severity?	☐Yes ☐No	*Submit documentation of beneficiary's response to therapy.*
2. Will the beneficiary be monitored and/or treated for helminth infection as recommended in package labeling?	☐Yes	☐No

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

Prescriber Signature:	**Date**: