PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Nucala - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Nucala - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Nucala (mepolizumab)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 18.]

2.	Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, skip to question 10.]		
3.	Will the requested drug be used as an add-on maintenance treatment for the disease?	Y N	
	[If no, no further questions.]		
4.	Has the patient had an allergy, immunology or a pulmonary consult?	Y N	
	[If no, no further questions.]		
5.	Has the patient had a blood eosinophil count of at least 150 cells per microliter in the past 90 days OR 300 cells per microliter in the past 12 months?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
6.	Does the patient have documented poorly controlled asthma as evidenced by two or more exacerbations in the past 12 months experience despite the use of high-dose inhaled corticosteroids (ICS) as applicable for either of the following: A) for ages 12 to 17, ICS does must be 440 micrograms per day of fluticasone propionate (FP) (ex-actuator) or equivalent daily, or mid-strength approved maintenance dose of inhaled corticosteroid (ICS)-long-acting beta-agonist (LABA) combinations, B) for ages 18 years of age and older, ICS dose must be 880 micrograms per day of fluticasone propionate (FP) (ex-actuator) or equivalent daily, or the highest approved maintenance dose of ICS-LABA combinations?	Y N	
	NOTE: Submission of medical records is required.		
	[If no, no further questions.]		
7.	Does the patient have documented treatment with at least 2 other controllers in addition to an inhaled corticosteroid (ICS) or an inhaled corticosteroid (ICS)-long-acting beta-agonist (LABA) combination (i.e., long-acting beta-agonist [if not already using an ICS-LABA combination], an asthma-indicated long-acting anticholinergic agent, leukotriene modifier, or theophylline), for at 6 months and demonstrated adherence of 80 percent or greater?	Y N	
	NOTE: Submission of medical records is required.		
	[If yes, skip to question 9.]		
8.	Does the patient have a documented allergy, contraindication, or an intolerance to any of the following specified prerequisite agent: A) long-acting beta-agonist (if not already using an inhaled corticosteroid (ICS)-long-acting beta-agonist (LABA) combination), B) an asthma-indicated long-acting anticholinergic agent, C) leukotriene modifier, D) theophylline?	Y N	

NOTE: Submission of medical records is required.		
[If no, no further questions.]		
9. Is the patient 6 years of age or older?	Y N	
[If yes, skip to question 17.]		
[If no, no further questions.]		
10. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
11. Has the patient had an allergy, immunology, pulmonary, or rheumatology consult?	Y N	
[If no, no further questions.]		
12. Has the patient had a documented trial and failure, or contraindication with at least one of the following immunosuppressants: A) azathioprine, B) cyclophosphamide, or C) methotrexate?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
13. Is there documentation that the patient is stable on corticosteroids, or has a contraindication to using corticosteroids?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
14. Is there documentation of severe disease (vasculitis with gastrointestinal, cardiac, cerebral, or renal involvement), or symptom recurrence with tapering of corticosteroid therapy?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
15. Does the patient have a documented diagnosis based on the history or presence of at least four of the following diagnostic criteria: A) asthma, B) eosinophilia (greater than 10 percent eosinophils on the differential leukocyte count), C) biopsy showing evidence of eosinophilic vasculitis, D) transient pulmonary infiltrates, E) mononeuropathy or polyneuropathy, F) paranasal sinus abnormalities?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
16. Is the patient 18 years of age or older?	Y N	
[If no, no further questions.]		
17. Will the requested drug be used concurrently with another biologic?	Y N	
[No further questions.]		

18. Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 20.]		
19. Is there documentation showing the patient's clinical improvement from treatment as supported by ONE of the following: A) reduction in asthma symptoms (wheezing, coughing, shortness of breath, chest tightness), B) reduction in administration frequency of short-acting rescue medication, C) reduction in exacerbation frequency and asthma-related hospitalizations (no increase in inhaled or oral corticosteroid dose), D) elevation in predicted forced expiratory volume in one second (FEV1) from the patient's baseline before treatment?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 22.]		
[If no, no further questions.]		
20. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
21. Is there documentation showing the patient's clinical improvement from treatment as supported by ONE of the following: A) decrease in maintenance dose of systemic corticosteroids, B) improvement in Birmingham Vasculitis Activity Score (BVAS) score compared to baseline, C) improvement in asthma symptoms or exacerbation, D) patient is in remission, defined as a BVAS equal to zero and a prednisone or prednisolone daily dose of less than or equal to 7.5 milligrams, E) improvement in duration of remission, or decrease in the rate of relapses?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
22. Is the patient adherent to 80 percent of the requested drug as well as other controller medications?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
23. Will the requested drug be used concurrently with another biologic?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date