Nucala

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical (POS Code 24)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *On Campus Outpatient Hospital (POS Code 22)*
❑ *Office (POS Code 11)*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

Request Initiated For: _____

Criteria Questions:

What is the ICD-10 code? _____

1. Will the requested drug be used concomitantly with any other biologic (e.g., Adbry, Humira, Dupixent), or targeted synthetic drug (e.g., Rinvoq, Olumiant, Otezla, Xeljanz) for the same indication?

❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?

❒ Asthma, *Continue to 3*

Send completed form to: Priority Partners Fax: 1-866-212-4756

❒ Eosinophilic granulomatosis with polyangiitis (EGPA), *Continue to 18*

❒ Hypereosinophilic syndrome (HES), *Continue to 28*

❒ Chronic rhinosinusitis with nasal polyps (CRSwNP), *Continue to 40*

❒ Other, please specify. _____, *No further questions*

3. Is the medication prescribed by or in consultation with an allergist, immunologist, or pulmonologist?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. Is the patient 6 years of age or older?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. Is the request for continuation of therapy with Nucala?
❒ Yes, *Continue to 6*
❒ No, *Continue to 10*

6. Is the patient currently receiving Nucala through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 10*

❒ No, *Continue to 7*

❒ Unknown, *Continue to 10*

7. Has asthma control improved on Nucala treatment as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of improved asthma control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 9*
❒ No, *Continue to 8*

8. Has asthma control improved on Nucala treatment as demonstrated by a reduction in the daily maintenance oral corticosteroid dose? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of improved asthma control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Will the patient continue to use maintenance asthma treatments (e.g., inhaled corticosteroid, additional controller) in combination with Nucala?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

10. Has the patient previously received another biologic drug (e.g., Dupixent, Xolair) indicated for asthma? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical records, or claims history of previous biologic drug tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 11*

11. Does the patient have uncontrolled asthma as demonstrated by experiencing two or more asthma exacerbations requiring oral or injectable corticosteroid treatment within the past year? ***ACTION REQUIRED***: If

Yes, please submit supporting chart notes, medical records, or claims history of previous corticosteroid use for asthma exacerbations including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 14*
❒ No, *Continue to 12*

12. Does the patient have uncontrolled asthma as demonstrated by experiencing one or more asthma exacerbation resulting in hospitalization or emergency medical care visit within the past year? ***ACTION REQUIRED***: If Yes, please submit supporting chart notes, medical records of previous asthma exacerbations requiring hospitalization or emergency medical visit. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 14*
❒ No, *Continue to 13*

13. Does the patient have uncontrolled asthma as demonstrated by experiencing poor symptom control (frequent symptoms or reliever use, activity limited by asthma, night waking due to asthma) within the past year? ***ACTION REQUIRED***: If Yes, please submit supporting chart notes or medical records. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Prior to requesting Nucala, did the patient have inadequate asthma despite current treatment with both of the following medications at optimized doses: 1) High dose inhaled corticosteroids AND 2) Additional controller (i.e., long acting beta2-agonist, long acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline)? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried including drug, dose, frequency, and duration. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. What is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? Indicate blood eosinophilic count in cells per microliter. ***ACTION REQUIRED***: Please attach supporting chart note(s) or medical record with the patient's baseline blood eosinophil count.
❒ Greater than or equal to 150 cells per microliter _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 17*
❒ Less than 150 cells per microliter _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 16*
❒ Unknown, *Continue to 16*

16. Is the patient dependent on systemic corticosteroids? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s) or medical record showing patient's dependance on systemic corticosteroids. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Will the patient continue to use maintenance asthma treatments (i.e., inhaled corticosteroids, additional controller) in combination with Nucala?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

18. Is the patient 18 years of age or older?

❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is the request for continuation of therapy with Nucala?
❒ Yes, *Continue to 20*
❒ No, *Continue to 22*

20. Is the patient currently receiving Nucala through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 22*

❒ No, *Continue to 21*

❒ Unknown, *Continue to 22*

21. Does the patient have beneficial response to treatment with Nucala as demonstrated by any of the following: A) A reduction in the frequency of relapses, B) A reduction in the daily oral corticosteroid dose, or C) No active vasculitis. ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of improved EGPA control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

22. Does the patient have a history of or the presence of a blood eosinophil count greater than 1000 cells per microliter or blood eosinophil level greater than 10%? Indicate blood eosinophil count in cells per microliter or percentage. ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s) or medical record with the patient's pretreatment blood eosinophil count.
❒ Yes - blood eosinophil count greater than 1000 cells per microliter _____ cells/microliter ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*
❒ Yes - blood eosinophil level greater than 10% _____ cells/microliter ***ACTION REQUIRED****: Submit supporting documentation, Continue to 23*

❒ No, *Continue to 23*

23. Does the patient have at least two of the following disease characteristics of eosinophilic granulomatosis with polyangiitis (EGPA): A) Biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation, B) Neuropathy, mono or poly (motor deficit or nerve conduction abnormality), C) Pulmonary infiltrates, non-fixed, D) Sino-nasal abnormality, E) Cardiomyopathy (established by echocardiography or magnetic resonance imaging), F) Glomerulonephritis (hematuria, red cell casts, proteinuria), G) Alveolar hemorrhage (by bronchoalveolar lavage), H) Palpable purpura, I) Anti-neutrophil cytoplasmic anti-body (ANCA) positive (Myeloperoxidase or proteinase 3)?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Has the patient had at least one relapse (requiring increase in oral corticosteroids dose, initiation/increased dose of immunosuppressive therapy or hospitalization) within 2 years prior to starting treatment with Nucala?
❒ Yes, *Continue to 26*
❒ No, *Continue to 25*

25. Does the patient have a refractory disease?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Is the patient currently receiving treatment with oral corticosteroids?

❒ Yes, *No Further Questions*
❒ No, *Continue to 27*

27. Are oral corticosteroids contraindicated or not tolerated?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

28. Is the patient 12 years of age or older?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Is the request for continuation of therapy with Nucala?
❒ Yes, *Continue to 30*
❒ No, *Continue to 33*

30. Is the patient currently receiving Nucala through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 33*
❒ No, *Continue to 31*
❒ Unknown, *Continue to 33*

31. Has the patient experienced a reduction in hypereosinophilic syndrome (HES) flares since starting treatment with Nucala? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of improved HES control. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

32. Will the patient receive Nucala as monotherapy (i.e., without any other hypereosinophilic syndrome [HES] medications)?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

33. Does the patient have hypereosinophilic syndrome (HES) secondary to a non-hematologic cause (e.g., drug hypersensitivity, parasitic helminth infection, [human immunodeficiency virus] HIV infection, non-hematologic malignancy)?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Does the patient have FIP1L1-PDGFRA kinase-positive hypereosinophilic syndrome (HES)? ***ACTION REQUIRED***: If No, please attach FIP1L1-PDGFRA fusion gene test results. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 35*
❒ No, *Continue to 35*

35. Has the patient had hypereosinophilic syndrome (HES) for at least 6 months?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Does the patient have a history or presence of a blood eosinophil count of at least 1000 cells per microliter? Indicate blood eosinophil count in cells per microliter. ***ACTION REQUIRED***: If Yes, please attach supporting

chart note(s) or medical record with the patient's pretreatment blood eosinophil count. _____cells/microliter ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

37. Will the patient receive Nucala as monotherapy (i.e., without any other hypereosinophilic syndrome [HES] medications)?
❒ Yes, *Continue to 38*
❒ No, *Continue to 38*

38. Is the patient on a stable dose of hypereosinophilic syndrome (HES) therapy (e.g., oral corticosteroid, immunosuppressive, and/or cytotoxic therapy)?
❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

39. Has the patient experienced at least two hypereosinophilic syndrome (HES) flares within the past 12 months?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

40. Is the medication prescribed by or in consultation with an allergist/immunologist or otolaryngologist?
❒ Yes, *Continue to 41*
❒ No, *Continue to 41*

41. Is the patient 18 years of age or older?
❒ Yes, *Continue to 42*
❒ No, *Continue to 42*

42. Is the request for continuation of therapy with Nucala?
❒ Yes, *Continue to 43*
❒ No, *Continue to 47*

43. Is the patient currently receiving Nucala through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 47*
❒ No, *Continue to 44*
❒ Unknown, *Continue to 47*

44. Has the patient achieved or maintained a positive clinical response to Nucala therapy as evidenced by improvement in signs and symptoms of chronic rhinosinusitis with nasal polyps (CRSwNP) (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain or reduction in corticosteroid use)? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes or medical record documentation of positive clinical response. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 45*
❒ No, *Continue to 45*

45. Will the patient continue to use a daily intranasal corticosteroid while being treated with Nucala?
❒ Yes, *No Further Questions*
❒ No, *Continue to 46*

46. Are intranasal corticosteroids contraindicated or not tolerated?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

47. Has the patient previously received another biologic drug (e.g., Dupixent, Xolair) indicated for CRSwNP? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical records, or claims history of previous biologic drug tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 48*

48. Does the patient have bilateral nasal polyps and chronic symptoms of sinusitis?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. Has the patient had intranasal corticosteroid treatment for at least 2 months? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 51*
❒ No, *Continue to 50*

50. Are intranasal corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Has the patient had prior sino-nasal surgery?
❒ Yes, *Continue to 54*
❒ No, *Continue to 52*

52. Has the patient had an inadequate response with systemic corticosteroids within the last two years? ***ACTION REQUIRED***: If Yes, please attach supporting chart notes, medical records, or claims history of previous medications tried. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 54*
❒ No, *Continue to 53*

53. Are systemic corticosteroids contraindicated or not tolerated? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Has the patient had a bilateral nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril? ***ACTION REQUIRED***: If Yes, please attach supporting chart note(s) or medical record showing endoscopy, rhinoscopy, or CT details (e.g., polyps location, size). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 57*
❒ No, *Continue to 55*

55. Has the patient had a Meltzer Clinical Score of 2 or higher in both nostrils? ***ACTION REQUIRED***: If Yes, please submit chart notes or medical records of Meltzer Clinical score. ***ACTION REQUIRED***: Submit supporting documentation

❒ Yes, *Continue to 57*
❒ No, *Continue to 56*

56. Has the patient had a total endoscopic nasal polyps score (NPS) of at least 5 with a minimum score of 2 for each nostril? ***ACTION REQUIRED***: If Yes, please submit chart notes or medical records of endoscopic nasal polyps score. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

57. Does the patient have symptoms of nasal blockage, congestion, or obstruction?
❒ Yes, *Continue to 58*
❒ No, *Continue to 58*

58. Does the patient have rhinorrhea (anterior/posterior), reduction or loss of smell, or facial pain or pressure?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Will the patient continue to use a daily intranasal corticosteroid while being treated with Nucala?
❒ Yes, *No Further Questions*
❒ No, *Continue to 60*

60. Are intranasal corticosteroids contraindicated or not tolerated?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

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