TRICARE Prior Authorization Request Form for
mepolizumab injection (**Nucala**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization approves for up to 300mg for eosinophilic granulomatosis with polyangiitis (EGPA)

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. What is the patient's diagnosis?	☐ severe persistent eosinophilic asthma - Proceed to question **2** ☐ eosinophilic granulomatosis with polyangiitis (EGPA) - Proceed to question **6** ☐ Other indication or diagnosis- **STOP- Coverage not approved**		
2. Is the requested medication being prescribed by an allergist, immunologist, or pulmonologist?		☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have an eosinophilic phenotype asthma as defined as either: • **blood eosinophil count of GREATER than 150 cells/mcL within the past month while on oral corticosteroids OR** • **GREATER than or EQUAL to 300 cells/mcL within the past year?**		☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient's asthma been uncontrolled despite adherence to optimized medication therapy regimen? **Uncontrolled asthma is defined as:** • **hospitalization for asthma in the past year, OR** • **requiring a course of oral corticosteroids twice in the past year, OR** • **daily high-dose inhaled corticosteroid (ICS) with inability to taper off the ICS.**		☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

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5. Has the patient tried and failed an adequate course (3 months) of at least two of the following while using a high-dose inhaled corticosteroid: • **Inhaled long-acting beta agonist (LABA) (for example, Serevent, Striverdi),** • **Long-acting muscarinic antagonist (LAMA) (for example, Spiriva, Incruse),** • **Leukotriene receptor antagonist (for example, Singulair, Accolate, Zyflo)?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
6. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Is the requested medication being prescribed by an allergist, immunologist, pulmonologist, rheumatologist, or hematologist?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had an adequate trial of at least 3 months of one of the following: corticosteroids, cyclophosphamide, azathioprine, or methotrexate and had an inadequate response to therapy, OR significant side effects/toxicity?	☐ Yes **Sign and date below**	☐ No Proceed to question **9**
9. Does the patient have a contraindication to therapy with corticosteroids, cyclophosphamide, azathioprine, or methotrexate?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[08 July 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: