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* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*_____ *Route of administration*_____
*Dosing frequency*_____

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

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Criteria Questions:

1. What is the diagnosis?
   - ❑ Asthma
   - ❑ Eosinophilic granulomatosis with polyangiitis (EGPA)
   - ❑ Hypereosinophilic syndrome (HES)
   - ❑ Other _____
2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Asthma

3. Will the patient receive Nucala as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)? ❑ Yes ❑ No
4. Will the patient receive Nucala concomitantly with other biologics indicated for asthma (e.g., Cinqair, Dupixent, Fasenra, Xolair)?
   ❑ Yes ❑ No
5. Is the request for continuation of therapy with Nucala? ❑ Yes ❑ No *If No, skip to #8*
6. Is the patient currently receiving Nucala through samples or a manufacturer's patient assistance program?
   ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #9*
7. Has asthma control improved on Nucala treatment as demonstrated by at least one of the following?
   ❑ Yes ❑ No *No further questions*
   a) A reduction in the frequency and/or severity of symptoms and exacerbations
   b) A reduction in the daily maintenance oral corticosteroid dose
8. Does the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses?
   ❑ Yes ❑ No If Yes, s*kip to #10*
   a) Inhaled corticosteroid
   b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)
9. Prior to receiving Nucala, did the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses? ❑ Yes ❑ No
   a) Inhaled corticosteroid
   b) Additional controller (long acting $beta_2$-agonist, leukotriene modifier, or sustained-release theophylline)
10. What is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record with the patient's baseline blood eosinophil count.*** _____ cells per microliter ❑ Unknown
11. Is the patient dependent on systemic corticosteroids? ❑ Yes ❑ No

Section B: Eosinophilic Granulomatosis with Polyangiitis

12. Is the request for continuation of therapy with Nucala? ❑ Yes ❑ No *If No, skip to #15*
13. Is the patient currently receiving Nucala through samples or a manufacturer's patient assistance program?
    ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #15*
14. Does the patient have beneficial response to treatment with Nucala as demonstrated by ANY of the following? ***Indicate below and no further questions.***
    - ❑ A reduction in the frequency of relapses
    - ❑ A reduction in the daily oral corticosteroid dose
    - ❑ No active vasculitis
    - ❑ None of the above

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15. Does the patient have a history or the presence of a blood eosinophil count greater than 1000 cells per microliter or blood eosinophil level greater than 10%? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record.***
    - ❑ Yes - blood eosinophil count greater than 1000 cells per microliter
    - ❑ Yes - blood eosinophil level greater than 10%
    - ❑ No

16. Does the patient have at least two of the following disease characteristics of eosinophilic granulomatosis with polyangiitis (EGPA)? ***Indicate ALL that apply or mark " None of the above."***
    - ❑ Biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation
    - ❑ Neuropathy, mono or poly (motor deficit or nerve conduction abnormality)
    - ❑ Pulmonary infiltrates, non-fixed; sino-nasal abnormality
    - ❑ Cardiomyopathy (established by echocardiography or magnetic resonance imaging)
    - ❑ Glomerulonephritis (hematuria, red cell casts, proteinuria)
    - ❑ Alveolar hemorrhage (by bronchoalveolar lavage)
    - ❑ Palpable purpura
    - ❑ Anti-neutrophil cytoplasmic anti-body (ANCA) positive (Myeloperoxidase or proteinease 3)
    - ❑ None of the above

17. 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? *If Yes, no further questions* ❑ Yes ❑ No

18. Does the patient have a refractory disease? ❑ Yes ❑ No

Section C: Hypereosinophilic syndrome

19. Is the request for continuation of therapy with Nucala? *If No, skip to #23* ❑ Yes ❑ No

20. Is the patient currently receiving Nucala through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No ❑ Unknown *If Yes or Unknown, skip to #23*

21. Has the patient experienced a reduction in hypereosinophilic syndrome (HES) flares since starting treatment with Nucala? ❑ Yes ❑ No

22. Will the patient receive Nucala as monotherapy (i.e., without any other hypereosinophilic syndrome [HES] medications)? *No further questions* ❑ Yes ❑ No

23. 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 ❑ No

24. Does the patient have FIP1L1-PDGFRA kinase-positive hypereosinophilic syndrome (HES)? ***ACTION REQUIRED*: *Please attach FIP1L1-PDGFRA fusion gene test results.*** ❑ Yes ❑ No

25. Has the patient had hypereosinophilic syndrome (HES) for at least 6 months? ❑ Yes ❑ No

26. Does the patient have a history or presence of a blood eosinophil count of at least 1000 cells per microliter? ***ACTION REQUIRED: Please attach supporting chart note(s) or medical record?*** ❑ Yes ❑ No

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27. Will the patient receive Nucala as monotherapy (i.e., without any other hypereosinophilic syndrome [HES] medications)? ❑ Yes ❑ No

28. Is the patient on a stable dose of hypereosinophilic syndrome (HES) therapy (e.g., oral corticosteroid, immunosuppressive, and/or cytotoxic therapy)? ❑ Yes ❑ No

29. Has the patient experienced at least two hypereosinophilic syndrome (HES) flares within the past 12 months? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

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

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