

Pharmacy Request for Prior Approval Monoclonal Antibody Therapy- Nucala

Beneficiary Information

1. Beneficiary Last Name: _____	2. First Name: _____	
3. Beneficiary ID #: _____	4. Beneficiary Date of Birth: _____	5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____	9. Strength: _____	10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): <input type="checkbox"/> up to 30 <input type="checkbox"/> 60 <input type="checkbox"/> 90 <input type="checkbox"/> 120 <input type="checkbox"/> 180 <input type="checkbox"/> 365 <input type="checkbox"/> Other: _____		

Clinical Information

For initial therapy:

Asthma (answer questions 1-10)

1. Is the member's age 6 or greater? Yes ___ No ___
2. Does the member have a diagnosis of severe asthma with an eosinophilic phenotype? Yes ___ No ___
3. Does the member have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Nucala) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%? Yes ___ No ___ Please list eosinophil count _____
4. Does the member have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist? Yes ___ No ___
5. Does the member have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months? Yes ___ No ___ Please List: _____
6. Does the member have prebronchodilator FEV1 below 80% in adults and 90% in adolescents? Yes ___ No ___ Please List FEV1 value _____
7. Is Nucala being used as add on maintenance treatment? Yes ___ No ___
8. Is Nucala being used for the treatment of other eosinophilic conditions? Yes ___ No ___
9. Is Nucala being used for the relief of acute bronchospasm or status asthmaticus? Yes ___ No ___
10. Is Nucala being used as dual therapy with other monoclonal antibody treatments? Yes ___ No ___

For continuation of therapy:

Asthma (answer question 11)

11. Has the member experienced continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the member's current asthma status and response to Nucala treatment? Yes ___ No ___ **Please attach medical records to this request.

For initial therapy:

Eosinophilic Granulomatosis with Polyangiitis (answer questions 12-13)

12. Is the member 18 years old or older? Yes ___ No ___
13. Does the member have a diagnosis of Eosinophilic Granulomatosis with Polyangiitis? Yes ___ No ___

For continuation of therapy:

Eosinophilic Granulomatosis with Polyangiitis (answer question 14)

14. Has the member shown clinical benefit from baseline supported by medical records since beginning Nucala? Yes ___ No ___ **Please attach medical records to this request.

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.