AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Monoclonal Antibodies: Nucala

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: Initial Request: __up to 30 days __60 days __90 days __120 days __180 days
Reauthorization Request: __up to 30 days __60 days __90 days __120 days __180 days __365 days

Clinical Information

Severe Asthma Initial Authorization:

1. Is the beneficiary 6 years of age or older? Yes___ No___
2. Does the beneficiary have a diagnosis of severe eosinophilic asthma? Yes___ No___
3. Does the beneficiary 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 beneficiary 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 beneficiary 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___
List: _____
6. Does the beneficiary have pre-bronchodilator FEV1 below 80% in adults and 90% in adolescents? Yes___ No___
Please list FEV1 value: _____
7. Is Nucala being used as an 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___

Severe Asthma Re-authorization (Please answer questions 1-11): **Attach Medical Documentation to this PA request form**

11. Has the beneficiary had continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Nucala treatment? Yes___ No___

Eosinophilic Granulomatosis with Polyangiitis Initial Authorization:

12. Is the beneficiary 18 years old or older? Yes___ No___
13. Does the beneficiary have a diagnosis of Eosinophilic Granulomatosis with Polyangiitis? Yes___ No___

Eosinophilic Granulomatosis with Polyangiitis Re-authorization (Please answer questions 12-14): **Attach Medical Documentation to this PA request form**

14. Has the beneficiary shown clinical benefit from baseline supported by medical records since beginning Nucala? Yes___ No___

Hypereosinophilic Syndrome (HES) Initial Authorization:

15. Is the beneficiary 12 years of age or older? Yes___ No___
16. Does the beneficiary have a diagnosis of Hypereosinophilic Syndrome (HES) with no identifiable non-hematologic secondary cause?
Yes___ No___

Hypereosinophilic Syndrome (HES) Re-authorization (Please answer questions 15-17): **Attach Medical Documentation to this PA request form**

17. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records? Yes___ No___

Nasal Polyps Initial Authorization

18. Is the beneficiary 18 years of age or older? Yes___ No___
19. Does the beneficiary have a diagnosis of chronic rhinosinusitis with nasal polyps? Yes___ No___
20. Has the beneficiary tried and failed monotherapy with nasal steroids? Yes___ No___
21. Will the beneficiary continue to receive intranasal steroids concomitantly with Nucala? Yes___ No___

Nasal Polyps Re-authorization (Please answer questions 18-22): **Attach Medical Documentation to this PA request form**

22. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records? Yes___ No___

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.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406