OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare

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Nucala® (mepolizumab) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Drug Information

☐ **Physician billing (HCPCS code:_____)** ☐ **Pharmacy billing* (NDC:_____)**

*If Nucala® vial for injection is being used & billed by a pharmacy, the medication should be shipped to the health care facility where it will be administered.

Dose:_____ Regimen:_____ Fill Date: _____

Billing Provider Information

Provider NPI:_____ Provider Name:_____

Provider Phone:_____ Provider Fax:_____

If Nucala® vial for injection will be used, please provide the name of outpatient health care facility where Nucala® will be delivered to and administered at:_____

Prescriber Information

Prescriber NPI:_____ Prescriber Name:_____

Prescriber Phone:_____ Prescriber Fax:_____ Specialty:_____

Clinical Information

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. **For Nucala® in a health care facility:**
   A. Will the injection be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes☐ No☐
2. **For Nucala® prefilled autoinjector or prefilled syringe for self-administration:**
   A. Has the member or caregiver been trained by a health care professional on subcutaneous administration, monitoring for any allergic reactions, and storage of Nucala®? Yes☐ No☐
3. Was Nucala® prescribed by a specialist or has the member been evaluated by a specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is a specialist)? Yes☐ No☐
   If yes, please include name of specialist: _____ Specialty: _____
4. **Please indicate diagnosis and information:**

☐ **Eosinophilic Granulomatosis with Polyangiitis (EGPA)**

A. Please check all that apply:
   ☐ Member has a past history of at least 1 confirmed EGPA relapse [requiring increase in oral corticosteroid (OCS) dose, initiation/increased dose of immunosuppressive therapy, or hospitalization] within the past 12 months.
   ☐ Member has refractory disease within the last 6 months following induction of standard treatment regimen administered compliantly for at least 3 months.
B. Is diagnosis granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)? Yes☐ No☐
C. Has member failed to achieve remission despite glucocorticoid therapy (oral prednisone equivalent equal to or greater than 7.5mg/day) for a minimum of 4 weeks duration? Yes☐ No☐

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization throughCoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.

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3. **Please indicate diagnosis and information, continued:**

☐ **Eosinophilic Phenotype Asthma**

A. Will this medication be used as add-on maintenance treatment for severe eosinophilic phenotype asthma? Yes☐ No☐
   i. If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:
   Drug/Dose: _____ Drug/Dose: _____
B. Baseline blood eosinophil count: _____ Date Determined: _____
C. Does member require daily systemic corticosteroids despite compliant use of a medium-to-high-dose inhaled corticosteroid (ICS) plus at least 1 additional controller medication? Yes☐ No☐
   i. If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _____ Dates of exacerbations: _____
D. Please check all that apply:
   ☐ Member has failed a medium-to-high-dose ICS used compliantly within the last 3-6 consecutive months.
   Drug/Dose: _____
   ☐ Member has failed at least 1 other asthma controller medication used in addition to the medium-to-high-dose ICS compliantly for at least the past 3 months.
   Drug/Dose: _____

☐ **Hypereosinophilic Syndrome (HES)**

A. Has member ben diagnosed with HES for ≥6 months without an identifiable non-hematologic secondary cause? Yes☐ No☐
B. Does member have a history of at least 2 confirmed HES flares [requiring increase in oral corticosteroid (OCS) dose, initiation/ increased dose of cytotoxic or immunosuppressive therapy, or hospitalization] within the past 12 months? Yes☐ No☐ Flare dates:_____
C. Please provide member's baseline blood eosinophil count: _____ Date taken:_____
D. Is HES FIP1L1-PDGFRα kinase-positive? Yes☐ No☐
E. Has member failed to achieve remission despite corticosteroid therapy (oral prednisone equivalent ≥10mg/day) for a minimum of 4 weeks duration? Yes☐ No☐
   i. If no, is member is unable to tolerate corticosteroid therapy due to significant side effects from glucocorticoid therapy? Yes☐ No☐

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3. **Please indicate diagnosis and information, continued:**

☐ **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**

A. Will Nucala® be used as add-on maintenance treatment for inadequately controlled CRSwNP? Yes☐ No☐

B. Does the member have a trial with intranasal corticosteroid that resulted in failure (or have a contraindication or documented intolerance)? Yes☐ No☐

i. If yes, please provide the medication used and dates of use: _____

C. Has the member required prior sino-nasal surgery? Yes☐ No☐

D. Has the member been treated with systemic corticosteroids for CRSwNP in the past 2 years (or have a contraindication or documented intolerance)? Yes☐ No☐

E. Does the member have symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management ? Yes☐ No☐

F. Does the member have evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy? Yes☐ No☐

G. Will the member continue to receive intranasal corticosteroid therapy? Yes☐ No☐

i. If yes, does the member have a contraindication to intranasal corticosteroid therapy? Yes☐ No☐

a. If yes, please provide the member's contraindication: _____

H. Will Nucala® be used concurrently with other biologic medications? Yes☐ No☐

i. If yes, please provide patient-specific information to support the concurrent use of Nucala® with other biologic medications: _____

☐ **Chronic Obstructive Pulmonary Disease (COPD)**

A. Will Nucala® be used as add-on maintenance treatment for inadequately controlled COPD? Yes☐ No☐

B. Does member have moderate to very severe disease [i.e., GOLD 2, GOLD 3, or GOLD 4 airflow obstruction as demonstrated by forced expiratory volume in 1 second (FEV1) of <80% predicted]? Yes☐ No☐

C. Member's blood eosinophil count (recent level or historical level prior to treatment): _____

D. Has member experienced ≥2 moderate exacerbations (e.g., required treatment with systemic corticosteroids and/or antibiotics) or ≥1 severe exacerbation (e.g., required hospitalization or 24-hour observation in emergency department) in the last 12 months? Yes☐ No☐

E. Is member inadequately controlled on triple therapy combination (LABA/LAMA/ICS) used compliantly within the last 3-6 consecutive months, unless contraindicated? Yes☐ No☐

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For Continued Authorization:

1. Is the member compliant with therapy? Yes☐ No☐
2. Is the member responding well to therapy? Yes☐ No☐
3. If member's diagnosis includes **EGPA**, please check all that apply:
   - ☐ Member has a Birmingham Vasculitis Activity Score (BVAS) of zero
   - ☐ Member has few EGPA relapses from baseline
   - ☐ Member has had a decrease in daily OCS dose regimen from baseline
   - ☐ If none of the above, please provide additional information on member's response to therapy:
4. If member's diagnosis includes **HES**, please provide the following:
   - A. Is the member responding to Nucala® therapy? Yes☐ No☐
     - i. If yes, has member had fewer HES flares from baseline? Yes☐ No☐
       - a. Please provide number of HES flares: Baseline:_____ Current: _____
     - ii. If yes, has member had a decrease in daily OCS dosing from baseline? Yes☐ No☐
       - a. Please provide daily OCS dosing: Baseline: _____ Current: _____

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

Additional Information: _____

_____

_____

_____

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Prescriber Signature: _____ **Date:** _____
(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

Pharmacist Signature: _____ **Date:** _____
Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete all pages will result in processing delays.

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