

**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**  
**NUCALA® Prefilled Autoinjector and Syringe (mepolizumab)**  
**Fax back to: 1-855-799-2553**

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

**Physician Administered Drug:** This form is only to be used for members obtaining the medication from a pharmacy through billing the pharmacy benefit at point-of-sale.

**MEMBER INFORMATION**

**Last Name:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Medicaid ID Number:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Weight in Kilograms:** \_\_\_\_\_

**PRESCRIBER INFORMATION**

**Last Name:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**NPI Number:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Fax Number:** \_\_\_\_\_

**DRUG INFORMATION**

**Drug Name/Form:** \_\_\_\_\_

**Strength:** \_\_\_\_\_

**Dosing Frequency:** \_\_\_\_\_

**Length of Therapy:** \_\_\_\_\_

**Quantity per Day:** \_\_\_\_\_

The Virginia Department of Medical Assistance Services considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasentra®, Nucala®, Tezspire™ and Xolair® to be experimental and investigational. Safety and efficacy of these combinations have **NOT** been established and will **NOT** be permitted.

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

**DIAGNOSIS AND MEDICAL INFORMATION****For severe\* asthma initial approval, complete the following questions to receive a 6-month approval:**1. Is the member 6 years of age or older? **AND** Yes       No2. Does the member have a diagnosis of severe\* asthma? **AND** Yes       No3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils  $\geq 150$  cells/ $\mu$ L? **AND** Yes       No4. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)? **AND** Yes       No5. Will this be used for add-on maintenance treatment in members regularly receiving **both** (unless otherwise contraindicated) of the following:

- Medium- to high-dose inhaled corticosteroids; **AND**
- An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers)?

 Yes       No6. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **or** one exacerbation resulting in a hospitalization? **AND** Yes       No

7. Does the member have at least one of the following for assessment of clinical status:

- Use of systemic corticosteroids
- Use of inhaled corticosteroids
- Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
- Forced expiratory volume in 1 second (FEV<sub>1</sub>)? **AND**

 Yes       No

8. Has the member tried and failed an adequate trial of the 2 different preferred products (Fasenra® and Xolair®)?

 Yes       No*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**For severe asthma renewal, complete the following questions to receive a 12-month approval:**

9. Has the member been assessed for toxicity? **AND**

Yes       No

10. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:

- Use of systemic corticosteroids
- Hospitalizations
- ER visits
- Unscheduled visits to healthcare provider
- Improvement from baseline in forced expiratory volume in 1 second (FEV<sub>1</sub>)?

Yes       No

**For eosinophilic granulomatosis with polyangiitis§ (EGPA) initial approval, complete the following questions to receive a 6-month approval:**

11. Is the member 18 years of age or older? **AND**

Yes       No

12. Does the member have a confirmed diagnosis of EGPA (aka Churg-Strauss Syndrome)? **AND**

Yes       No

13. Does the member have blood eosinophils  $\geq 1000$  cells/ $\mu$ L or  $\geq 10\%$  eosinophils on white blood cell differential count? **AND**

Yes       No

14. Has the member been on stable doses of concomitant oral corticosteroid therapy for at least 4 weeks (i.e., prednisone or prednisolone at a dose of 7.5 mg/day)? **AND**

Yes       No

15. Has the physician assessed baseline disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS], history of asthma symptoms and/or exacerbations, duration of remission, rate of relapses)?

Yes       No

16. Has the member tried and failed an adequate trial of the preferred product Fasenra®?

Yes       No

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**For EGPA renewal, complete the following questions to receive a 12-month approval:**

17. Has the member been assessed for toxicity? **AND**

Yes       No

18. Does the member have disease response as indicated by improvement in signs and symptoms compared to baseline as evidenced in one or more of the following:

- Member is in remission [defined as a Birmingham Vasculitis Activity Score (BVAS) score=0 and a prednisone/prednisolone daily dose of  $\leq 7.5$  mg]
- Decrease in maintenance dose of systemic corticosteroids
- Improvement in BVAS score compared to baseline
- Improvement in asthma symptoms or asthma exacerbations
- Improvement in duration of remission or decrease in the rate of relapses?

Yes       No

**For hypereosinophilic syndrome (HES) initial approval, complete the following questions to receive a 6-month approval:**

19. Is the member 12 years of age or older? **AND**

Yes       No

20. Has the member been diagnosed with HES (without an identifiable non-hematologic secondary cause (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy) or FIP1L1-PDGFR $\alpha$  kinase-positive HES) for at least 6 months prior to starting treatment? **AND**

Yes       No

21. Has the member had a history of 2 or more HES flares within the previous 12 months (e.g., documented HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy)? **AND**

Yes       No

22. Will this be used in combination with stable doses of at least one other HES therapy, (e.g., oral corticosteroids, immunosuppressive agents, cytotoxic therapy) unless the member cannot tolerate other therapy?

Yes       No

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**For HES renewal, complete the following questions to receive a 12-month approval:**

23. Has the member been assessed for toxicity? **AND**

Yes       No

24. Does the member have disease response as indicated by a decrease in HES flares from baseline?

**Note:** An HES flare is defined as worsening of clinical signs and symptoms of HES or increasing eosinophils (on at least 2 occasions), resulting in the need to increase oral corticosteroids or increase/add cytotoxic or immunosuppressive HES therapy.

Yes       No

**For chronic rhinosinusitis with nasal polyps (CRSwNP) initial approval, complete the following questions to receive a 6-month approval:**

25. Is the member 18 years of age or older? **AND**

Yes       No

26. Does the member have bilateral symptomatic sino-nasal polyposis with symptoms lasting at least 8 weeks? **AND**

Yes       No

27. Has the member failed at least 8 weeks of intranasal corticosteroid therapy? **AND**

Yes       No

28. Will therapy be used in combination with intranasal corticosteroids unless unable to tolerate or is contraindicated? **AND**

Yes       No

29. Has the member tried and failed an adequate trial of the preferred product Xolair®?

Yes       No

**For CRSwNP renewal, complete the following questions to receive a 12-month approval:**

30. Has the member been assessed for toxicity? **AND**

Yes       No

31. Does the member have disease response as indicated by improvement in signs and symptoms compared to baseline in one or more of the following: nasal/obstruction symptoms, improvement of sinus opacifications as assessed by CT-scans and/or an improvement on a disease activity scoring tool [e.g., nasal polyposis score (NPS), nasal congestion (NC) symptom severity score, sinonasal outcome test-22 (SNOT-22), etc.]? **OR**

Yes       No

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

32. Did the member have improvement in at least one of the following response criteria:

- Reduction in nasal polyp size
- Reduction in need for systemic corticosteroids
- Improvement in quality of life
- Improvement in sense of smell
- Reduction of impact of comorbidities?

Yes       No

**For inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype initial approval, complete the following questions to receive a 6-month approval:**

33. Is the member 18 years of age or older? **AND**

Yes       No

34. Does the member have a diagnosis of COPD with moderate to very severe airflow limitation, as defined by FEV<sub>1</sub>/FVC ratio < 0.7 and post-bronchodilator FEV<sub>1</sub> of 20% to 80% predicted? **AND**

Yes       No

35. Does the member have a peripheral blood eosinophil count ≥ 150 cells/μL at screening or ≥ 300 cells/μL in the year prior? **AND**

Yes       No

36. Will therapy be used for add-on maintenance treatment in members regularly receiving background triple inhaled therapies (i.e. ICS, long-acting beta agonist, and long-acting muscarinic antagonist) unless otherwise contraindicated? **AND**

Yes       No

37. Has the member had at least 2 moderate (requiring treatment with oral/systemic corticosteroids and/or antibiotics) or 1 severe (requiring inpatient hospitalization) COPD exacerbation in the previous year, despite receiving triple inhaled therapy? **AND**

Yes       No

38. Has the member tried and failed an adequate trial of Dupixent, unless contraindicated?

Yes       No       N/A

a. **If N/A was selected**, does the member have a peripheral blood eosinophil count < 300 cells/μL at screening?

Yes       No

**For COPD renewal, complete the following questions to receive a 12-month approval:**

39. Has the member been assessed for toxicity? **AND**

Yes       No       N/A

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

40. Does the member have improvement in COPD symptoms or COPD exacerbations as evidenced by decrease in one or more of the following:

- Use of systemic corticosteroids
- Use of antibiotics
- Hospitalizations
- ER visits
- Unscheduled visits to healthcare provider
- Improvement from baseline in forced expiratory volume in 1 second (FEV<sub>1</sub>)

Yes       No

**\* Components of severity for classifying asthma as *severe* may include any of the following (not all-inclusive):**

- Asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA
- Asthma that requires high-dose ICS-LABA to prevent it from being uncontrolled
- Symptoms throughout the day
- Nighttime awakenings, often 7 times/week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV<sub>1</sub>) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

**§ Eosinophilic Granulomatosis Polyangiitis (EGPA) is defined as all of the following:**

- History or presence of asthma
- Blood eosinophil level > 10% or an absolute count > 1000 cells/mm<sup>3</sup>
- Two or more of the following criteria:
  - Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil rich granulomatous inflammation
  - Neuropathy
  - Pulmonary infiltrates
  - Sinonasal abnormalities
  - Cardiomyopathy
  - Glomerulonephritis
  - Alveolar hemorrhage
  - Palpable purpura
  - Antineutrophil Cytoplasmic Antibody (ANCA) positivity

(Form continued on next page.)

**Member's Last Name:**

**Member's First Name:**

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**Prescriber Signature (Required)**

**Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the PA process.**

Submission of documentation does NOT guarantee coverage.