FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Nucala® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Eosinophilic granulomatosis with polyangitis (EGPA)

❑ Severe eosinophilic asthma

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Nucala is prescribed by or in consultation with one of the following specialists:

- ❑ Allergist/Immunologist
- ❑ Pulmonologist
- ❑ Rheumatologist

For eosinophilic granulomatosis with polyangitis (EGPA), answer the following:

Has the patient's disease relapsed or is the disease refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy)? ❑ **Yes** ❑ **No**

Is the patient currently receiving corticosteroid therapy (e.g., prednisolone, prednisone)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation that the patient has had a positive clinical response to therapy (e.g., increase in remission time)? ❑ **Yes** ❑ **No**

For severe eosinophilic asthma, answer the following:

Select to confirm the asthma is an eosinophilic phenotype as defined by the following:

- ❑ Baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter
- ❑ Peripheral blood eosinophil levels were greater than or equal to 300 cells/microliter within the past 12 months

Has the patient had at least one or more asthma exacerbations requiring systemic corticosteroids within the past 12 months? ❑ **Yes** ❑ **No**

Has the patient had any prior intubation for an asthma exacerbation? ❑ **Yes** ❑ **No**

Has the patient had prior asthma-related hospitalization within the past 12 months? ❑ **Yes** ❑ **No**

Select if the patient is currently being treated with, or has a contraindication, or intolerance to the following:

- ❑ High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- ❑ Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline)
- ❑ One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])

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Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications)? ❑ **Yes** ❑ **No**

Select if the patient is currently being treated with, or has a contraindication, or intolerance to the following:

- ❑ Inhaled corticosteroid (ICS)
- ❑ Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline)
- ❑ A combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.