Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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# Montana Healthcare Programs Prior Authorization Request Form for Use of Nucala (mepolizumab)

| | | |
|---|---|---|
| Member Name: | DOB: | Date: |
| Medicaid ID: | Prescriber Phone: | |
| Prescriber Name/Specialty: | Prescriber Fax: | |
| Requested Dose/Directions: | | |

***Please complete below information for applicable situation, <u>Initiation</u> or <u>Continuation</u> of therapy:***

☐ **INITIATION OF THERAPY- Please check appropriate diagnosis and complete corresponding information:**

**a)** ☐ **<u>Severe asthma with an eosinophilic phenotype</u>**

a. Prescriber practices in one of the following specialty clinics: ☐ Allergy ☐ Pulmonology ☐ Immunology

- ***Action Required:*** If not in a specialty clinic, information on annual consult with an appropriate specialist is required: Name: _____ Contact Date: _____

b. Initial baseline peripheral blood eosinophil count: Date:_____Results:_____ cells/microliter
(within past 6 weeks) (Criteria ≥150cells/microliter)

**a)** ***Action Required: Attach lab report with eosinophil count***

c. Member has a history of *severe* asthma attacks despite treatment with BOTH of the following medications at optimized doses **in combination** for 3 consecutive months:

☐ Inhaled corticosteroid (ICS): Name:_____Dates:_____

☐ Long-acting beta$_2$-agonist: Name:_____ Dates: _____

d. Provider attests that member will not use Nucala (mepolizumab) concomitantly with other biologics (e.g., Cinqair, Dupixent, Fasenra, Xolair) ☐ YES

**b)** ☐ **<u>Eosinophilic granulomatosis with polyangiitis (EGPA)</u>**

a. Prescriber practices in one of the following specialty clinics:☐Rheumatology☐ Pulmonology☐Immunology

- ***Action Required:*** If not in a specialty clinic, information on annual consult with an appropriate specialist is required: Name: _____ Contact Date: _____

b. Member is experiencing exacerbations while on a stable dose of oral corticosteroid or during steroid taper:☐Yes☐ No

c. Immunosuppressive therapy has been ineffective, contraindicated, or not tolerated: ☐ Yes ☐ No

d. List medications tried/dates and any other pertinent clinical information: _____

**c) ☐ Hypereosinophilic Syndrome (HES)**

a. Member is 12 years of age or older ☐ Yes ☐ No

b. Prescriber must be a specialist (Allergy/Immunology/Pulmonolgy/Neurology/Cardiology/Dermatology) or have an annual consult on file: ☐ Yes ☐ No

- ***Action Required:*** If not in a specialty clinic, information on annual consult with an appropriate specialist is required: Name: _____ Contact Date: _____

c. Member has diagnosis of hypereosinophilic syndrome for >6 months ☐ Yes ☐ No

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

a. Member is 18 years of age or older: ☐ Yes ☐ No

b. Medication is prescribed by, or in consultation with, an appropriate specialist:

☐Allergist ☐Immunologist ☐Otolaryngologist

- ***Action Required:*** If not in a specialty clinic, information on annual consult with an appropriate specialist is required: Name: _____ Contact Date: _____

c. Member has clinical documentation of chronic rhinosinusitis WITH nasal polyps as evidenced by CT scan or endoscopy: ☐Yes ☐No

d. Member must have had an inadequate treatment response, intolerance, or contraindication to both of the following:

1. One different intranasal corticosteroids*:
   - Name: _____ Date: _____
   **Note: Must have been adherent to therapy at optimized doses for at least 3 months.*

2. Systemic corticosteroid trial (must be within last year) and/or sino-nasal surgery:
   - Name: _____ Date: _____

   AND/OR

   - Surgery Date: _____

e. Member will concurrently use an intranasal corticosteroid: ☐ Yes ☐ No - Contraindicated in member

- If contraindicated, please explain: _____

f. Provider attests that member will not use Nucala® concomitantly with other biologics: ☐ Yes ☐ No

**Initial authorization will be granted for 6 months for Asthma/EGPA/HES and 1 year for CRSwNP**

## LIMITATIONS:

**Severe Asthma:** Member ≥ 12 years of age, max 100 mg SQ every 4 weeks. Member 6-11 years, max 40 mg SQ q 4 wks.
**EGPA:** Member must be ≥18 years of age, max 300 mg SQ every 4 weeks. Administered by healthcare professional.
**HES**: Member must be ≥12 years of age, max 300 mg SQ every 4 weeks.
**CRSwNP**:Member must be ≥18 years of age, max 100 mg SQ every 4 weeks.

☐ **CONTINUATION OF THERAPY:**

1. Member has been adherent to Nucala® therapy (applies to all diagnoses): ☐ Yes ☐ No (will be verified through claims history)

2. **For Severe Eosinophilic Asthma diagnosis only:** member has been adherent to ICS/LABA therapy: ☐ Yes ☐ No (will be verified through claims history)

3. **For *CRSwNP* diagnosis only**: member has been adherent to intranasal corticosteroid therapy: ☐ Yes ☐ No (will be verified through claims history)

4. Documentation **must be attached** supporting positive response to therapy:

   - Asthma/HES/EGPA: reduction in the frequency and/or severity of symptoms and exacerbations, or medication dose reduction

   - CRSwNP: reduction in polyp size, time to first nasal polypectomy, change in loss of smell, systemic steroid use

5. Annual specialist consult is attached if prescriber is not a specialist. ☐ Yes ☐ No ☐ N/A prescriber is specialist

**Reauthorization will be issued for 1 year.**

**LIMITATIONS:**
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**HES**: Member must be ≥12 years of age, max 300 mg SQ every 4 weeks.
**CRSwNP**:Member must be ≥18 years of age, max 100 mg SQ every 4 weeks.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit @ 1-800-294-1350

06/2022