

State of Oklahoma SoonerCare

Nucala[®] (Mepolizumab) Prior Authorization Form

Me	ember N	lame:					
			Drug Information				
	Phys	ician	billing (HCPCS code:) Pharmacy billing* (NDC:) ection is being used and billed by a pharmacy, the medication should be shipped to the health care facility where it will be administered.				
*If	Nucala [®] via	al for inje	ection is being used and billed by a pharmacy, the medication should be shipped to the health care facility where it will be administered. **Regimen: Fill Date:				
	03e						
S	oonor()	aro Pi	Billing Provider Information Provider ID:				
			rovider ID: Provider Name:e:Provider Fax:				
			for injection will be used, please provide the name of outpatient health care facility where				
N	nucaia ucala® v	viai vill be	e delivered to and administered at:				
			Prescriber Information				
Pr	escribe	r NPI:	Prescriber Name:				
Sp	ecialty:		Prescriber Phone: Prescriber Fax:				
			Clinical Information				
Pa	ge 1 of 2	- Pleas	se complete and return all pages. Failure to complete all pages will result in processing delays.				
Fo			rization (Initial approval will be for the duration of 6 months):				
1.			vial for injection:				
	A.		Nucala [®] vial for injection be administered in a health care setting by a health care professional ared to manage anaphylaxis? Yes No				
2.		ıcala®	prefilled autoinjector or prefilled syringe:				
	A.		he member or caregiver been trained by a health care professional on subcutaneous				
		administration of Nucala [®] prefilled autoinjector or prefilled syringe, monitoring for any allergic reactions, and storage of Nucala [®] prefilled autoinjector or prefilled syringe? YesNo					
3.	Please		ate diagnosis and information:				
		Severe Eosinophilic Phenotype Asthma					
A. Will this medication be used as add-on maintenance treatment for severe eosinophilic							
			otype asthma? Yes No If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:				
		D	Drug/Dose:				
			line blood eosinophil count: Date Determined:				
	C.		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		ed corticosteroid (ICS) plus at least 1 additional controller medication? Yes No If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12					
			months: Number: Dates of exacerbations:				
	D.		he member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months				
			n advanced care practitioner with a supervising physician who is an allergist, problem on a supervising physician who is an allergist, problem on a supervising physician who is an allergist, problem on a supervising physician who is an allergist, problem on a supervision of the				
			yes, please include name of specialist:				
	E.	_	se check all that apply:				
		u	Member has failed a medium-to-high-dose ICS used compliantly for at least the past 12 months Drug/ Dose:				
			Member has failed at least 1 other asthma controller medication used in addition to the medium-to-high-				
d			dose ICS compliantly for at least the past 3 months				
	Eosino	nhilic	- Drug/Dose: Granulomatosis with Polyangiitis (EGPA)				
_	A.	Does	member have a past history of at least 1 confirmed EGPA relapse [requiring increase in oral				
corticosteroid (OCS) dose, initiation/increased dose of immunosuppres			osteroid (OCS) dose, initiation/increased dose of immunosuppressive therapy, or hospitalization] within the				
	R	past 1	12 months? Yes No member have refractory disease within the last 6 months following induction of standard				
	۵.		nent regimen administered compliantly for at least 3 months? Yes No				
	LEASE PR	OVIDE .	THE INFORMATION REQUESTED AND RETURN TO: CONFIDENTIALITY NOTICE				

University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014

Phone: 1-800-522-0114 Option 4

This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.



SoonerCare

Nucala® (Mepolizumab) Prior Authorization Form

State of Oklahoma

Page 2 of 2—Please complete and return all pages. Filture to complete all pages will result in processing delays. Please indicate diagnosis and information, continued: Cosinophilic Granulomatosis with Polyangilitis (EGPA), continued C. Is diagnosis granulomatosis with polyangilitis (EGPA) or microscopic polyangilitis (MPA)? Yes No. No. No. No. No. No. No. Please No. D. 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. No	Me	ember N	Name: Member II)#:				
3. Please indicate diagnosis and information, continued □ Eosinophilic Granulomatosis with Polyangilits (EGPA), continued □ C. Is diagnosis granulomatosis with polyangilits (IGPA) or microscopic polyangilits (MPA)? Yes No D. 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 E. Has the member been evaluated by an allergist, pulmonologist, pulmonary specialist, or rheumatologist (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, pulmonary specialist, or rheumatologist) within the past 12 months? Yes No If yes, please include name of specialist: □ Hypercosinophilic Syndrome (HES) A. Has member been 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: Date taken:			Clinical Information					
C. Is diagnosis granulomatosis with Polyangiitis (EOPA), continued C. Is diagnosis granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)? Yes. No. D. 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. E. Has the member been evaluated by an allergist, pulmonologist, pulmonary specialist, or rheumatologist (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, pulmonary specialist, or rheumatologist) within the past 12 months? Yes. No. If yes, please include name of specialist: □ Hypereosinophilic Syndrome (HES) A. Has member been 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: D is HES FIP-IL-1POEFRα 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. F. Is the prescriber a hematologist or a specialist with expertise in treatment of HES (or an advanced care practitioner with a supervising physician who is a hematologist or a specialist with expertise in treatment of HES)? Yes. No. □ Other, please list: For Continued Authorization: 1. Is 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 a decrease in daily OCS dose regimen from baseline? Yes. No. A. Is the member responding to Nucala® therapy? Yes. No. A. I	Pag	ge 2 of 2	2—Please complete and return all pages. Failure to complete all pages will result in	n processing delays.				
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for a minimum of 4 weeks duration? YesNo		E.	. Is the strict i-robberta kinase-positive? Tes No Has member failed to achieve remission despite corticosteroid therapy (oral predni	sone equivalent ≥10mg/day)				
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a. Please provide daily OCS dosing: Baseline: Current: 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. Prescriber Signature: Date: (By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) Pharmacist Signature: Date:				No.				
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Pharmacist Signature: Date:	(Ry signature the physician confirms the criteria information above is accurate and verifiable in national records.)							
Pharmacist Signature: Date:	, ,	_		patient records.				
Diagon do not good in about notes. Considia information will be requested if necessary. Follows to consulate all manages will	Ph	armac	cist Signature: Date:	o to complete all personall				

result in processing delays.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014

Phone: 1-800-522-0114 Option 4

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