

**PRIOR AUTHORIZATION REQUEST FORM
NUCALA® for Eosinophilic Granulomatosis**

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

- For **Medical Pharmacy** please fax requests to 801-213-1547
- For **Retail Pharmacy** requests please fax requests to: 888-509-8142

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	HCPCS Code:	

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being request: Nucala® (mepolizumab)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS- EGPA (FORMERLY CHURG-STRAUSS SYNDROME)			
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the request made by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a past medical history or presence of asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does documentation show blood eosinophil level of $\geq 10\%$ or an absolute count $>1000\text{cells}/\text{mm}^3$?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does the member have a confirmed diagnosis of Eosinophilic Granulomatosis with Polyangiitis (Churg-Strauss Syndrome) with at least 2 of the following: <ul style="list-style-type: none"> • Neuropathy • Pulmonary infiltrates • Sinonasal abnormality • Cardiomyopathy • Glomerulonephritis • Alveolar hemorrhage • Palpable purpura • Antineutrophil cytoplasmic antibody (ANCA) positivity • Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration or eosinophil 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

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rich granulomatous inflammation			
6. Has the member been on a stable corticosteroid dose for at least 4 weeks prior to Nucala® therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Has the member had a trial and failure of immunosuppressants for maintenance therapy including azathioprine, methotrexate, or leflunomide?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
8. Does documentation show objective baseline severity (e.g. nighttime awakenings, daytime symptoms, FEV1, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show that the member has experienced a positive clinical response of at least one of the following: <ul style="list-style-type: none"> • reduction in the frequency and/or severity of relapses • reduction or discontinuation of doses of corticosteroids and/or immunosuppressants • disease remission • reduction in severity or frequency of EGPA-related symptoms 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy: PHARM- 048
 Origination Date: 01/31/2018
 Reviewed/Revised Date: 08/18/2021
 Next Review Date: 08/18/2022
 Current Effective Date: 09/01/2021

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