HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
NUCALA® FOR HYPEREOSINOPHILIC SYNDROME

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 requested: ☐ Nucala® (mepolizumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of hypereosinophilic syndrome of ≥ 6 months without an identifiable non-hematologic secondary cause?	☐	☐	
2. Does documentation show the member is negative for platelet-derived growth factor receptor alpha (*PDGFRA*) and FIP1L1?	☐	☐	**Please provide documentation**
3. Has the member been on a stable dose oral corticosteroids, immunosuppressants or cytotoxic therapy such as hydroxyurea or methotrexate for ≥ 4 months?	☐	☐	**Please provide documentation**
4. Does the member have a blood eosinophil count of > 1,500 eosinophils/µL on 2 examinations at least 1 month apart and/or tissue eosinophilia?	☐	☐	**Please provide documentation**
5. Have other causes of elevated eosinophils and/or organ damage been ruled out?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a positive response to therapy evidenced by a reduction in frequency of HES flares?	☐	☐	**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 Signature:

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Policy: PHARM-106
Origination Date: 10/12/2020
Reviewed/Revised Date: 10/28/2020
Next Review Date: 10/28/2021
Current Effective Date: 11/01/2020