HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
NUCALA® FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

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

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

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

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 confirmed diagnosis of chronic rhinosinusitis with nasal polyposis as noted on a current exam?	☐	☐	**Please provide documentation**
2. Has the member tried and failed, or has contraindication/intolerance to, Dupixent® (dupilumab)? Please note: Dupixent® requires prior authorization	☐	☐	**Please provide documentation**
3. Is the request made by, or in consultation with, an allergist, pulmonologist or ENT specialist?	☐	☐	
4. Has the member had at least a three-month trial and failure of Xhance® (fluticasone) nasal spray in addition to saline lavage? Please note: Xhance® requires prior authorization	☐	☐	**Please provide documentation**
5. Has the member tried and failed at least two weeks of systemic corticosteroid therapy?	☐	☐	**Please provide documentation**
6. Has the member tried and failed at least two weeks of doxycycline or macrolide antibiotic use?	☐	☐	**Please provide documentation**
7. Will Nucala® be used in combination with intranasal corticosteroid therapy?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member show a continued need for therapy?	☐	☐	**Please provide documentation**

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3. Has the member experienced reduction in nasal polyp size and nasal congestion?	☐	☐	**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- 122
Origination Date: 10/06/2021
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