Iowa Department of Human Services

Request for Prior Authorization
MEPOLIZUMAB (NUCALA)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for mepolizumab (Nucala). Requests will not be considered with concurrent use of omalizumab. Payment will be considered under the following conditions: 1) Patient meets the FDA approved age; and 2) Patient has a diagnosis of severe asthma with an eosinophilic phenotype; and 3) Patient has a pretreatment blood eosinophil count of ≥150 cells per mcL within the previous 6 weeks or blood eosinophils of ≥300 cells per mcL within 12 months prior to initiation of therapy; and 4) Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of 3 consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and 5) Patient has a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and 6) A pretreatment forced expiratory volume in 1 second (FEV_1) <80% predicted; and 7) Prescriber is an allergist, immunologist, or pulmonologist.

If the criteria for coverage are met, an initial authorization will be given for 3 months to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met: 1) Patient continues to receive therapy with an ICS, LABA and LTRA; and 2) Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or 3) Patient has experienced a decrease in administration of rescue medication (albuterol); or 4) Patient has experienced a decrease in exacerbation frequency; or 5) Patient has experienced an increase in predicted FEV_1 from the pretreatment baseline. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Nucala Auto-Injector ☐ Nucala Prefilled Syringe

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Pretreatment blood eosinophil count (attach lab): _____ Date Obtained: _____

OR

Blood eosinophil count obtained within 12 months prior to initiation of treatment (attach lab): _____

Date Obtained: _____

Pretreatment Baseline ppFEV$_1$: _____ Date Obtained: _____

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Document current use of:

High-dose inhaled corticosteroid: Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start date:_____

Long-Acting Beta2-Agonist: Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start date:_____

Leukotriene Receptor Antagonist: Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start date:_____

Does patient have a history of two (2) or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA? ☐ No ☐ Yes (provide dates):_____

Prescriber's specialty: ☐ Allergist ☐ Immunologist ☐ Pulmonologist ☐ Other:_____

Will the patient be taking omalizumab in combination with mepolizumab? ☐ No ☐ Yes

For Renewals Only:

Does patient continue to receive therapy with an ICS, LABA and LTRA? ☐ No ☐ Yes

Please indicate if the patient has experienced any of the following (check all that apply):

☐ Reduction in asthma signs and symptoms including:
- wheezing
- chest tightness
- coughing
- shortness of breath

☐ Decrease in administration of rescue medications (albuterol)

☐ Decrease in exacerbation frequency

☐ Increase in ppFEV$_1$ from the pretreatment baseline Current ppFEV$_1$:_____ Date Obtained:_____

Please describe:_____

_____

Medical or contraindication reason to override trial requirements:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*