SoonerCare
Oklahoma Health Care Authority

# State of Oklahoma SoonerCare
# Nucala® (Mepolizumab) Prior Authorization Form

***Member Name:*** _____ ***Date of Birth:*** _____ ***Member ID#:*** _____

## Drug Information

❑ Physician billing (HCPCS code:_____) ❑ Pharmacy billing (NDC:_____)

***Dose:*** _____ ***Regimen:*** _____ ***Fill Date:*** _____

## Billing Provider Information

***SoonerCare Provider ID:*** _____ ***Provider Name:*** _____

***Provider Phone:*** _____ ***Provider Fax:*** _____

## Prescriber Information

***Prescriber NPI:*** _____ ***Prescriber Name:*** _____

***Specialty:*** _____ ***Prescriber Phone:*** _____ ***Prescriber Fax:*** _____

## Clinical Information

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.

1. What is the diagnosis for which the medication is being prescribed?
   - ❑ Severe eosinophilic phenotype asthma
   - ❑ Other, please list: _____
2. Will this medication be used as add-on maintenance treatment for severe eosinophilic phenotype asthma? Yes___ No___
3. If yes, please indicate member's daily medications and dose prescribed for the treatment of this diagnosis:
   Drug/Dose: _____ Drug/Dose: _____
   Drug/Dose: _____ Drug/Dose: _____
4. Baseline blood eosinophil count: _____ Date Determined: _____
5. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last twelve months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes___ No___
6. If yes, please include name of specialist: _____
7. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes___ No___
8. If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months:
   Number: _____ Dates of exacerbations: _____
9. Please check all that apply:
   - ❑ Member has failed a high-dose ICS (≥ 880 mcg/day fluticasone propionate or equivalent daily dose or ≥ 440 mcg/day in ages 12 to 17) used compliantly for at least the past 12 months (for ICS/LABA combination products, the highest approved dose meets this criteria) -
     Drug/Dose: _____
   - ❑ Member has failed at least one other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past three months -
     Drug/Dose: _____

***Members must be adherent for continued approval. Initial approvals will be for the duration of six months after which time compliance will be evaluated for continued approval.***

**Prescriber Signature:** _____ **Date:** _____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

**Pharmacist Signature:** _____ **Date:** _____

***Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will 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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