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:_____)

*If medication is being billed by a pharmacy, the medication should be shipped to the healthcare facility where it will be administered.

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

Billing Provider Information

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

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

Name of outpatient healthcare facility where Nucala® will be delivered to and administered at:

_____

Prescriber Information

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

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

Clinical Information

Page 1 of 2—Please complete and return <u>all</u> pages. *Failure to complete all pages will result in processing delays.*

For Initial Authorization (Initial approval will be for the duration of 6 months):

1. Will Nucala® be administered in a healthcare setting by a healthcare professional prepared to manage anaphylaxis? Yes☐ No☐
2. Please indicate diagnosis and information:

❑ **Severe eosinophilic phenotype asthma**

A. Will this medication be used as add-on maintenance treatment for severe eosinophilic phenotype asthma? Yes☐ No☐
   i. If yes, please indicate member's daily medications and dose prescribed for treatment of this diagnosis:
   Drug/Dose: _____ Drug/Dose: _____

B. Baseline blood eosinophil count: _____ Date Determined: _____

C. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes☐ No☐
   i. If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months: Number: _____ Dates of exacerbations: _____

D. 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☐
   If yes, please include name of specialist: _____

E. 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: _____

Please complete and return <u>all</u> pages. *Failure to complete all pages will result in processing delays.*

Please do not send in chart notes. Specific information will be requested if necessary.

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>
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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Clinical Information

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2. Please indicate diagnosis and information, continued:
   E. Please check all that apply, continued:
   - ❑ 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: _____

☐ **Eosinophilic Granulomatosis with Polyangiitis (EGPA)**

A. Does member have a past history of at least one confirmed EGPA relapse [requiring increase in oral corticosteroid (OCS) dose, initiation/increased dose of immunosuppressive therapy, or hospitalization] within the 12 months? Yes☐ No☐

B. Does member have refractory disease within the last 6 months following induction of standard treatment regimen administered compliantly for at least 3 months? Yes☐ No☐

C. Is diagnosis granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)? Yes☐ No☐

D. Has member failed to achieve remission despite glucocorticoid therapy (oral prednisone equivalent equal to or greater than 7.5mg/day) for a minimum of 4 weeks duration? Yes☐ No☐

E. Has the member been evaluated by an allergist, pulmonologist, pulmonary specialist, or rheumatologist or the member must have been evaluated by an allergist, pulmonologist, pulmonary specialist, or rheumatologist within the last twelve months (or be an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, pulmonary specialist, or rheumatologist) Yes☐ No☐

If yes, please include name of specialist: _____

☐ **Other, please list:** _____

For Continued Authorization:

1. Is member compliant with therapy? Yes☐ No☐
2. If member's diagnosis includes EGPA, please check all that apply:
   - ❑ Member has a Birmingham Vasculitis Activity Score (BVAS) of zero
   - ❑ Member has fewer EGPA relapses from baseline
   - ❑ Member has had a decrease in daily OCS dose regimen from baseline
   - ❑ If none of the above, please provide additional information on member's response to therapy: _____

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.

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 complete and return all pages. *Failure to complete all pages will result in processing delays.*

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
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	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

OHCA Approved – 6/6/2018