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 Nucala® vial for injection is being used and billed by a pharmacy, the medication should be shipped to the health care facility where it will be administered.

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

Billing Provider Information

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

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

If Nucala® vial for injection will be used, please provide the name of outpatient health care 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 3 - Please complete and return all 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. **For Nucala® vial for injection:**
   - A. Will Nucala® vial for injection be administered in a health care setting by a health care professional prepared to manage anaphylaxis? Yes☐ No☐
2. **For Nucala® prefilled autoinjector or prefilled syringe:**
   - A. Has the member or caregiver been trained by a health care professional on subcutaneous administration of Nucala® prefilled autoinjector or prefilled syringe, monitoring for any allergic reactions, and storage of Nucala® prefilled autoinjector or prefilled syringe? Yes☐ No☐
3. **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 a medium-to-high-dose inhaled corticosteroid (ICS) plus at least 1 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 12 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 medium-to-high-dose ICS used compliantly within the last 3-6 consecutive months Drug/Dose: _____
  - ☐ Member has failed at least 1 other asthma controller medication used in addition to the medium-to-high-dose ICS compliantly for at least the past 3 months
    - Drug/Dose: _____

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

- A. Does member have a past history of at least 1 confirmed EGPA relapse [requiring increase in oral corticosteroid (OCS) dose, initiation/increased dose of immunosuppressive therapy, or hospitalization] within the past 12 months? Yes☐ No☐

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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Page 2 of 3—Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

3. **Please indicate diagnosis and information, continued:**

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

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 an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, pulmonary specialist, or rheumatologist) within the past 12 months? Yes☐ No☐
   i. If yes, please include name of specialist: _____

☐ **Hypereosinophilic Syndrome (HES)**

A. Has member been diagnosed with HES for ≥6 months without an identifiable non-hematologic secondary cause? Yes☐ No☐
B. Does member have a history of at least 2 confirmed HES flares [requiring increase in oral corticosteroid (OCS) dose, initiation/increased dose of cytotoxic or immunosuppressive therapy, or hospitalization] within the past 12 months? Yes☐ No☐ Flare dates:_____
C. Please provide member's baseline blood eosinophil count:_____ Date taken:_____
D. Is HES FIP1L1-PDGFRα kinase-positive? Yes☐ No☐
E. Has member failed to achieve remission despite corticosteroid therapy (oral prednisone equivalent ≥10mg/day) for a minimum of 4 weeks duration? Yes☐ No☐
   i. If no, is member is unable to tolerate corticosteroid therapy due to significant side effects from glucocorticoid therapy? Yes☐ No☐
F. Is the prescriber a hematologist or a specialist with expertise in treatment of HES (or an advanced care practitioner with a supervising physician who is a hematologist or a specialist with expertise in treatment of HES)? Yes☐ No☐

☐ **Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)**

A. Will Nucala® be used as add-on maintenance treatment for inadequately controlled CRSwNP? Yes☐ No☐
B. Does the member have a trial with intranasal corticosteroid that resulted in failure (or have a contraindication or documented intolerance)? Yes☐ No☐
   i. If yes, please provide the medication used and dates of use:_____
C. Has the member required prior sino-nasal surgery? Yes☐ No☐
D. Has the member been treated with systemic corticosteroids for CRSwNP in the past 2 years (or have a contraindication or documented intolerance)? Yes☐ No☐
E. Has the member been evaluated by an otolaryngologist, allergist, immunologist, or pulmonologist (or an advanced care practitioner with a supervising physician who is an allergist, otolaryngologist, allergist, immunologist, or pulmonologist) within the past 12 months? Yes☐ No☐
   i. If yes, please include name of specialist: _____
F. Does the member have symptoms of chronic rhinosinusitis (e.g., facial pain/pressure, reduction or loss of smell, nasal blockade/obstruction/congestion, nasal discharge) for 12 weeks or longer despite attempts at medical management ? Yes☐ No☐
G. Does the member have evidence of nasal polyposis by direct examination, sinus CT scan, or endoscopy? Yes☐ No☐
H. Will the member continue to receive intranasal corticosteroid therapy? Yes☐ No☐
   i. If yes, does the member have a contraindication to intranasal corticosteroid therapy? Yes☐ No☐
      1. If yes, please provide the member's contraindication:_____
I. Will Nucala® be used concurrently with other biologic medications? Yes☐ No☐
   i. If yes, please provide patient-specific information to support the concurrent use of Nucala® with other biologic medications:_____

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Page 3 of 3—Please complete and return all pages. *Failure to complete all pages will result in processing delays.*

For Continued Authorization:

1. Is the member compliant with therapy? Yes☐ No☐
2. Is the member responding well to therapy? Yes☐ No☐
3. 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:

     _____

3. If member's diagnosis includes **HES**, please provide the following:
   - A. Is the member responding to Nucala® therapy? Yes☐ No☐
     - i. If yes, has member had fewer HES flares from baseline? Yes☐ No☐
       - a. Please provide number of HES flares: Baseline:_____ Current:_____
     - ii. If yes, has member had a decrease in daily OCS dosing from baseline? Yes☐ No☐
       - a. Please provide daily OCS dosing: Baseline:_____ Current:_____

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 will be requested if necessary. Failure to complete all pages will result in processing delays.

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