AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Nucala™ (mepolizumab) **(Pharmacy)**
{Hypereosinophilic Syndrome (HES)}

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Recommended Dosage: 300mg/mL SubQ once every 4 weeks administered as 3 separate 100-mg injections

- ***AvMed considers the use of concomitant therapy with Cinqair®, Nucala™, Dupixent®, Fasenra®, and Xolair® to be experimental and investigational. Safety and efficacy of these combinations have not been established and will not be permitted.**
- **In the event a member has an active Cinqair®, Dupixent®, Fasenra® or Xolair authorization on file, any subsequent request for Nucala™ will not be approved.**

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval Length: 12 months

- ❑ Member is ≥ 12 years of age

AND

(Continued on next page)

- ❑ Prescriber is or has consulted with an Allergist, Immunologist, Pulmonologist or Rheumatologist

AND

- ❑ Member has a diagnosis of HES for 6 months or longer without any non-hematologic secondary cause (i.e. drug hypersensitivity, parasitic helminth infection, human immunodeficiency virus infection, non-hematologic malignancy) **(submit chart notes and labs confirming diagnosis)**

AND

- ❑ Member has FIP1L1-PDGFRα-negative disease

AND

- ❑ Member has had two or more episodes of HES-related flares (worsening of clinical symptoms and/or worsening of blood eosinophil counts) requiring escalation of therapy in the past 12 months **(submit chart notes)**

AND

- ❑ Member's HES-related flares occur spontaneously and did NOT occur within 4 weeks of a decrease in therapy

AND

- ❑ Member has been on a stable dose of HES therapy (such as oral corticosteroids, immunosuppressive agents and/or cytotoxic therapy) for the past 4 or more weeks **(verified by pharmacy paid claims)**

AND

- ❑ Member's blood eosinophil count is ≥ 1000 cells/microliter while taking stable doses of HES therapy **(submit labs obtained within 4 weeks of request)**

Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ The member has experienced a positive response to Nucala™ therapy as determined by the prescriber (i.e. decreased number of flares, improved fatigue, reduced corticosteroid requirements, and decreased eosinophil levels) **(submit chart notes)**

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****