

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)
Chronic rhinosinusitis with nasal polyps (CRSwNP)

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: _____

Quantity Limit: 100 mg per 28 days

*AvMed considers the use of concomitant therapy with Cinqair[®], Nucala[®], Dupixent[®], Fasentra[®], 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[®], Fasentra[®], and/or Xolair[®] authorization on file, any subsequent requests 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.

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❑ DIAGNOSIS: Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with an allergist, immunologist or otolaryngologist
- ❑ Member is 18 years of age or older
- ❑ Member has a **diagnosis of CRSwNP** confirmed by the American Academy of Otolaryngology-Head and Neck Surgery Clinical Practice Guideline (Update): Adult Sinusitis (AAO-HNSF 2015)/American Academy of Allergy Asthma & Immunology (AAAAI) with **ONE** of the following clinical procedures:
 - ❑ Anterior rhinoscopy
 - ❑ Nasal endoscopy
 - ❑ Computed tomography (CT)
- ❑ Documented diagnosis of chronic rhinosinusitis defined by at least 12 weeks of the following (**chart notes must be submitted**):
 - ❑ Mucosal inflammation **AND** at least **TWO** of the following:
 - ❑ Decreased sense of smell
 - ❑ Facial pressure, pain, fullness
 - ❑ Mucopurulent drainage
 - ❑ Nasal obstruction
- ❑ Member is currently being treated with medications in at least **TWO** of the following categories unless there is a contraindication or intolerance to these medications and must be compliant on therapy **for at least 90 consecutive days** within a year of request (**chart notes documenting contraindication(s) or intolerance must be attached; trials will be verified using pharmacy claims and/or submitted chart notes**):
 - ❑ Nasal saline irrigation
 - ❑ Intranasal corticosteroids (e.g., fluticasone, budesonide, triamcinolone)
 - ❑ Leukotriene receptor antagonists (e.g., montelukast, zafirlukast, zileuton)
- ❑ Member is refractory, ineligible or intolerant to **ONE** of the following:
 - ❑ Systemic corticosteroids
 - ❑ Sino-nasal surgery
- ❑ Member is requesting Nucala[®] (mepolizumab) as add-on therapy to maintenance intranasal corticosteroids

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.

- ❑ Member has experienced a positive clinical response to Nucala[®] therapy (e.g., reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, improved sense of smell) (**chart notes must be submitted**)

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- Decreased utilization of oral corticosteroids (**verified by pharmacy paid claims**)
- Member has been compliant on Nucala[®] therapy and continues to receive therapy with an intranasal corticosteroid (**verified by pharmacy paid claims**)

Medication being provided by (check box below that applies):

- Physician's office **OR** Specialty Pharmacy - PropriumRx

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.