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 Obstructive Pulmonary Disease (COPD)

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit: 100 mg per 28 days

***The Health Plan 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®, 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.

❑ **DIAGNOSIS: Chronic Obstructive Pulmonary Disease**

Initial Authorization: 12 months

❑ Prescribed by or in consultation with an allergist, immunologist or pulmonologist

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- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of moderate to severe Chronic Obstructive Pulmonary Disease (COPD) confirmed with spirometry demonstrating **ONE** of the following:
  - ❑ FEV1/FVC ratio <0.7 post-bronchodilation
  - ❑ Post-bronchodilator FEV1 % predicted of ≥ 30% and ≤ 80%
- ❑ Member has experienced **ONE** of the following:
  - ❑ At least two (2) exacerbations treated with short-acting bronchodilators and oral corticosteroids, with or without antibiotics in the past 12 months
  - ❑ At least one (1) exacerbation requiring hospitalization in the past 12 months
- ❑ Provider must submit a member blood eosinophil count level greater than or equal to 300 cells per microliter following at least 90 days of therapy of dual or triple-maintenance therapies
- ❑ Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications and must be compliant on therapy **for at least 90 consecutive days** within year of the request **(verified by pharmacy paid claims)**:
  - ❑ Triple therapy with a long-acting muscarinic antagonist (LAMA) (e.g., Spiriva Respimat®), long-acting beta agonist (LABA) (e.g., Advair HFA, Dulera®), and an inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
  - ❑ Dual therapy with a long-acting muscarinic antagonist (LAMA) (e.g., Spiriva Respimat®) and long-acting beta agonist (LABA) (e.g., Advair HFA, Dulera®) alone if inhaled corticosteroid (ICS) is contraindicated
- ❑ Member is requesting Nucala® (mepolizumab) as add-on maintenance therapy to dual or triple therapy **(verified by pharmacy paid claims)**

Reauthorization: 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 sustained positive clinical response to Nucala® therapy as demonstrated by at least **ONE** of the following **(check all that apply)**:
  - ❑ Increase in percent predicted Forced Expiratory Volume (FEV1) from baseline (pre-treatment)
  - ❑ Reduction in exacerbations (e.g., decrease oral corticosteroids) or fewer hospitalizations
  - ❑ Reduction in dyspnea symptoms such as chest tightness, shortness of breath
- ❑ Member is currently being treated with **ONE** of the following unless there is a contraindication or intolerance to these medications **(verified by pharmacy paid claims)**:
  - ❑ Triple therapy with a long-acting muscarinic antagonist (LAMA) (e.g., Spiriva Respimat®), long-acting beta agonist (LABA) (e.g., Advair HFA, Dulera®), and an inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
  - ❑ Dual therapy with a long-acting muscarinic antagonist (LAMA) (e.g., Spiriva Respimat®) and long-acting beta agonist (LABA) (e.g., Advair HFA, Dulera®) alone if inhaled corticosteroid (ICS) is contraindicated

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- ❑ Member continues to use Nucala® (mepolizumab) as add-on maintenance therapy to dual or triple therapy **(verified by pharmacy paid claims)**

Medication being provided by Specialty Pharmacy – Proprium Rx

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.*