Independence

Today's date: _____ **Intended date of injection:** _____

Prior Authorization Form – Nucala®

Buy-and-bill requests for this drug should be submitted through NaviNet®.

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Check one: ☐ New start ☐ Continued treatment

Patient information (please print)	Physician information (please print)	
Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of birth	Fax #	NPI

This drug will be delivered to the requesting physician.

**** A copy of the prescription must accompany the medication request for delivery.****

1) **Diagnosis for drug requested (must include ICD-10):** _____

2) **Patient medical information**
For severe asthma with an eosinophilic phenotype

a. Is the patient 12 years of age or older? ☐ Yes ☐ No

b. Have results of complete blood count (CBC) drawn at the initiation of treatment shown eosinophils of at least 150 cells/microliter, or eosinophils of at least 300 cells/microliter in the past 12 months? If yes, please fax this documentation along with this form. ☐ Yes ☐ No

c. Is the patient currently receiving treatment that does not maintain adequate control of asthma, and Nucala will be used as additional maintenance therapy? ☐ Yes ☐ No

d. Does the patient's current treatment include high-dose inhaled corticosteroids (ICE) (e.g., Flovent, Pulmicort), with or without oral corticosteroids, in combination with any of the following additional controllers? Check all that apply, and list the drug/dose/duration on the line provided below: ☐ Yes ☐ No

- ☐ Long-acting beta agonist (LABA) (e.g., Foradil, Serevent®); _____
- ☐ Combination high-dose ICE and LABA (e.g., Advair®, Symbicort®); _____
- ☐ Leukotriene receptor antagonist (e.g., Singulair®); _____
- ☐ Theophylline; _____
- ☐ Other; _____
- ☐ The patient is intolerant to or has a contraindication to these agents.

(continued on next page)

Independence

Prior Authorization Form – Nucala® (continued)

For relapsed or refractory eosinophilic granulomatosis with polyangiitis (EGPA)

a. Is the patient 18 years of age or older? ☐ Yes ☐ No

b. Does the patient have a history of asthma or a current asthma condition? ☐ Yes ☐ No

c. Have results of complete blood count (CBC) shown >10% of leukocytes or an absolute eosinophil count >1,000 cells/mm^3 (or >1 x 10^9/L) in the past six months? ☐ Yes ☐ No
If yes, please fax this documentation along with this form.

d. Does the patient currently have any of the following features typical of EGPA? ☐ Yes ☐ No
(check all that are currently present)

- ☐ Biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation
- ☐ Neuropathy
- ☐ Pulmonary infiltrates
- ☐ Sinonasal abnormality
- ☐ Cardiomyopathy
- ☐ Glomerulonephritis
- ☐ Alveolar hemorrhage
- ☐ Palpable purpura
- ☐ Positive test for antineutrophil cytoplasmic antibody (ANCA)

e. Does the patient's current treatment include oral corticosteroids? If no, is the patient intolerant to or have a contraindication to these agents? ____ Intolerance ___ Contraindication ☐ Yes ☐ No

Reason for intolerance or contraindication? _____

3) Prescription information

Quantity_____ refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Please fax this completed form to 215-761-9580.