

## NC Pharmacy Prior Approval Request for Monoclonal Antibodies: Nucala

### Beneficiary Information

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
 3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

### Prescriber Information

6. Prescribing Provider NPI #: \_\_\_\_\_ Provider Fax #: \_\_\_\_\_  
 7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

### Drug Information

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
 11. Length of Therapy (in days): Initial Request:  up to 30 Days  60 Days  90 Days  120 Days  180 Days  
 Continuation Request:  up to 30 Days  60 Days  90 Days  120 Days  180 Days  365 Days

### Clinical Information

#### Severe Asthma Initial Authorization:

1. Is the beneficiary 6 years of age or older?  Yes  No
2. Does the beneficiary have a diagnosis of severe eosinophilic asthma?  Yes  No
3. Does the beneficiary have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Nucala) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%?  Yes  No Please list eosinophil count: \_\_\_\_\_
4. Does the beneficiary have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist?  Yes  No
5. Does the beneficiary have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months?  Yes  No  
Please List: \_\_\_\_\_
6. Does the beneficiary have prebronchodilator FEV1 below 80% in adults and 90% in adolescents?  Yes  No  
Please List FEV1 value: \_\_\_\_\_
7. Is Nucala being used as add on maintenance treatment?  Yes  No
8. Is Nucala being used for the treatment of other eosinophilic conditions?  Yes  No
9. Is Nucala being used for the relief of acute bronchospasm or status asthmaticus?  Yes  No
10. Is Nucala being used as dual therapy with other monoclonal antibody treatments?  Yes  No

#### Severe Asthma Re-authorization (Please answer questions 1-11) **\*\*Attach Medical Documentation to this PA request form\*\***:

11. Has the beneficiary had continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Nucala treatment?  Yes  No

#### Eosinophilic Granulomatosis with Polyangiitis Initial Authorization:

12. Is the patient 18 years of age or older?  Yes  No
13. Does the beneficiary have a confirmed diagnosis of Eosinophilic Granulomatosis with Polyangiitis?  Yes  No

#### Eosinophilic Granulomatosis with Polyangiitis Re-authorization (Please answer questions 12-14) **\*\*Attach Medical Documentation to this PA request form\*\***:

14. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records?  Yes  No

#### Hypereosinophilic Syndrome (HES)

15. Is the beneficiary 12 years of age or older?  Yes  No
16. Does the beneficiary have a diagnosis of Hypereosinophilic Syndrome (HES) with no identifiable non-hematologic secondary cause?  Yes  No

#### Hypereosinophilic Syndrome (HES) Re-authorization (Please answer questions 15-17) **\*\*Attach Medical Documentation to this PA request form\*\***:

17. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records?  Yes  No

#### Nasal Polyps (Initial)

18. Is the beneficiary 18 years of age or older?  Yes  No
19. Does the beneficiary have a diagnosis of chronic rhinosinusitis with nasal polyps?  Yes  No
20. Has the beneficiary tried and failed monotherapy with nasal steroids?  Yes  No
21. Will the beneficiary continue to receive intranasal steroids concomitantly with Nucala?  Yes  No

#### Nasal Polyps (Re-authorization) (Please answer questions 18-22) **\*\*Attach Medical Documentation to this PA request form\*\***:

22. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records?  Yes  No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_  
**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.