Pharmacy Prior Authorization

AETNA BETTER HEALTH LOUISIANA (MEDICAID)

Nucala (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Louisiana at **1-844-699-2889**.
When conditions are met, we will authorize the coverage of Nucala (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Nucala (mepolizumab)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ ICD Code: _____

Circle the appropriate answer for each question.

1. Will Nucala be used in combination with other monoclonal antibodies used to treat asthma? Y N

   [If yes, no further questions.]

2. Has the prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements? Y N

   [If no, no further questions.]

3. Have all laboratory testing and clinical monitoring recommended in the Y N

prescribing information been completed as of the date of the request and will be repeated as recommended?

[If no, no further questions.]

4. Does the member have any inappropriate concomitant drug therapies or disease states? Y N

   [If yes, no further questions.]

5. Does the member have a diagnosis of severe asthma with an eosinophilic phenotype (severe allergic asthma)? Y N

   [If no, skip to question 16.]

6. Will Nucala be used in combination with an inhaled corticosteroid (ICS) plus either a long-acting beta agonist (LABA) OR another controller agent (e.g., leukotriene receptor agonist [LTRA])? Y N

   [If no, no further questions.]

7. Has this plan authorized Nucala in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 10.]

8. Has the member remained compliant with ONE of the following regimens: A) medium to high dose ICS plus a LABA, B) high dose ICS plus a LTRA (if the member is unable to take a LABA), C) high dose ICS plus theophylline (if the member is unable to take a LABA), or D) low to medium dose ICS plus tiotropium plus LTRA or theophylline (if the member is unable to take LABA and high dose ICS)? Y N

   [If no, no further questions.]

9. Is there documentation of clinically significant positive response to Nucala therapy? Y N

   [If yes, skip to question 15.]

   [If no, no further questions.]

10. Does the member have a peripheral blood eosinophil count of greater than or equal to 150 cells/microliter within the previous 6 weeks (prior to treatment with Nucala)? Y N

    Please document the date of lab drawn and results: _____

    [If yes, skip to question 12.]

11. Does the member have a peripheral blood eosinophil count of greater than or equal to 300 cells/microliter at any time within the previous 12 months? Y N

    Please document the date of lab drawn and results: _____

    [If no, no further questions.]

12. Has the member been compliant with ONE of the following regimens for at least 3 consecutive months: A) medium to high dose ICS plus a LABA, B) high dose ICS plus a LTRA (if the member is unable to take a LABA), C) high dose ICS plus theophylline (if the member is unable to take a LABA), or D) low to medium dose ICS plus tiotropium plus LTRA or theophylline (if the member is unable to take LABA and high dose ICS)? Y N

    [If no, no further questions.]

13. Even with compliant use of the above controller regimens, does the member's asthma continue to be uncontrolled as defined by ONE of the following: A) two or more asthma exacerbations which required treatment with systemic corticosteroids in the previous 12 months, B) one or more asthma exacerbations requiring hospitalization or an emergency department visit in the previous 12 months, C) FEV1 less than 80 percent predicted, D) FEV1/FVC less than 0.80, or E) asthma worsens upon tapering of oral corticosteroid therapy? Y N

    [If no, no further questions.]

14. Is the member 12 years of age or older on the date of the request? Y N

    [If no, no further questions.]

15. Will the dose of Nucala exceed 100 mg once every 4 weeks? Y N

    [No further questions.]

16. Does the member have a diagnosis of eosinophilic granulomatosis with polyangiitis (Churg-Strauss)? Y N

    [If no, no further questions.]

17. Has this plan authorized Nucala in the past for this member (i.e., previous authorization is on file under this plan)? Y N

    [If no, skip to question 19.]

18. Is there documentation of clinically significant positive response to Nucala therapy? Y N

    [If yes, skip to question 23.]

[If no, no further questions.]

19. Does the member have an absolute blood eosinophil count of greater than or equal to 150 cells/microliter within the last 3 months? Y N

    Please document the date of lab drawn and results: _____

    [If no, no further questions.]

20. Was the member compliant and has failed treatment with at least a 4 week trial of an oral corticosteroid? Y N

    [If yes, skip to question 22.]

21. Does the member have a contraindication or experienced clinically significant adverse events to an oral corticosteroid? Y N

    [If no, no further questions.]

22. Is the member 18 years of age or older on the date of the request? Y N

    [If no, no further questions.]

23. Will the dose of Nucala exceed 300 mg once every 4 weeks? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date