

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? Yes No
If yes, please fax this documentation along with this form.
- 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? Yes No
Check all that apply, and list the drug/dose/duration on the line provided below:
 - 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)

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/mm³ (or >1 x 10⁹/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? Yes No
 ____ Intolerance ____ Contraindication
 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 215-784-0672.