US Family Health Plan
Prior Authorization Request Form for mepolizumab injection (**Nucala**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization approves for up to 300mg for eosinophilic granulomatosis with polyangiitis (EGPA) and Hypereosinophilic Syndrome (HES).
Initial approvals expire after twelve months, renewal approvals are indefinite. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Nucala.*	☐ Yes (subject to verification) **proceed to question 2**	☐ No **Proceed to question 5**
2. What is the patient's diagnosis?	☐ severe persistent eosinophilic asthma - **Proceed to question 3** ☐ eosinophilic granulomatosis with polyangiitis (EGPA) - **Proceed to question 4** ☐ Hypereosinophilic Syndrome (HES) - **Proceed to question 4** ☐ Other indication or diagnosis- **STOP- Coverage not approved**	
3. Has the patient had a positive response to therapy defined as a decrease in asthma exacerbations, improvements in forced expiratory volume in one second (FEV1) or decrease in oral corticosteroid use?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Has the patient's disease severity improved and stabilized to warrant continued therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Is the patient currently receiving another immunobiologic (for example, benralizumab [Fasenra], dupilumab [Dupixent] or omalizumab [Xolair])?	☐ Yes **STOP** **Coverage not approved**	☐ No **Proceed to question 6**
6. What is the patient's diagnosis?	☐ severe persistent eosinophilic asthma - **Proceed to question 7** ☐ eosinophilic granulomatosis with polyangiitis (EGPA) - **Proceed to question 11** ☐ Hypereosinophilic Syndrome (HES) - **Proceed to question 13** ☐ Other indication or diagnosis- **STOP- Coverage not approved**	

7. Is the requested medication being prescribed by an allergist, immunologist, or pulmonologist?	☐ Yes **Proceed to question 8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have an eosinophilic phenotype asthma as defined as either: • **blood eosinophil count of GREATER than or EQUAL to 150 cells/mcL within the past month while on oral corticosteroids OR** • **blood eosinophil count of GREATER than or EQUAL to 300 cells/mcL within the past year?**	☐ Yes **Proceed to question 9**	☐ No **STOP** **Coverage not approved**
9. Has the patient's asthma been uncontrolled despite adherence to optimized medication therapy regimen? *Uncontrolled asthma is defined as one of the following: hospitalization for asthma in the past year, OR requiring a course of oral corticosteroids twice in the past year, OR requiring daily high-dose inhaled corticosteroid (ICS) with inability to taper off the ICS.*	☐ Yes **Proceed to question 10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and failed an adequate course (3 months) of at least TWO of the following while using a high-dose inhaled corticosteroid: • **Inhaled long-acting beta agonist (LABA) (for example, Serevent, Striverdi),** • **long-acting muscarinic antagonist (LAMA) (for example, Spiriva, Incruse),** • **leukotriene receptor antagonist (for example, Singulair, Accolate, Zyflo)?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes **Proceed to question 12**	☐ No **STOP** **Coverage not approved**
12. Is the requested medication being prescribed an allergist, immunologist, pulmonologist, rheumatologist, or hematologist?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
13. Has the patient had blood eosinophil count of GREATER than 1,000 cells/mcL in the past year?	☐ Yes **Proceed to question 14**	☐ No **STOP** **Coverage not approved**
14. Is the requested medication being prescribed an allergist, immunologist, pulmonologist, rheumatologist, or hematologist?	☐ Yes **Proceed to question 15**	☐ No **STOP** **Coverage not approved**
15. Is the patient GREATER THAN or EQUAL TO 12 years of age?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date