

USFHP 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

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

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.	<input type="checkbox"/> Yes (subject to verification)	<input type="checkbox"/> No Proceed to question 6
2. What is the patient's diagnosis?	<input type="checkbox"/> Severe persistent eosinophilic asthma - Proceed to question 3 <input type="checkbox"/> Eosinophilic granulomatosis with polyangiitis (EGPA) - Proceed to question 4 <input type="checkbox"/> Hypereosinophilic Syndrome (HES) - Proceed to question 4 <input type="checkbox"/> Chronic rhinosinusitis with nasal polyps (CRSwNP) - Proceed to question 5 <input type="checkbox"/> Moderate to severe Chronic Obstructive Pulmonary Disease (COPD) - Proceed to question 4 <input type="checkbox"/> 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?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
4. Has the patient's disease severity improved and stabilized to warrant continued therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
5. Is there evidence of effectiveness as documented by decrease in nasal polyps score or nasal congestion score?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

USFHP Prior Authorization Request Form for
mepolizumab injection (**Nucala**)

<p>6. What is the patient's age?</p>	<input type="checkbox"/> 18 years of age or older –proceed to question 7 <input type="checkbox"/> 17 years of age or younger –proceed to question 8	
<p>7. What is the indication or diagnosis for this adult patient?</p>	<input type="checkbox"/> Severe persistent eosinophilic asthma - Proceed to question 9 <input type="checkbox"/> Eosinophilic granulomatosis with polyangiitis - Proceed to question 13 <input type="checkbox"/> Hypereosinophilic Syndrome - Proceed to question 15 <input type="checkbox"/> Chronic rhinosinusitis with nasal polyps - Proceed to question 17 <input type="checkbox"/> Moderate to severe Chronic Obstructive Pulmonary Disease - Proceed to question 18 <input type="checkbox"/> Other indication or diagnosis- STOP- Coverage not approved	
<p>8. What is the indication or diagnosis for this pediatric patient?</p>	<input type="checkbox"/> Severe persistent eosinophilic asthma - Proceed to question 9 <input type="checkbox"/> Hypereosinophilic Syndrome - Proceed to question 14 <input type="checkbox"/> Other indication or diagnosis- STOP- Coverage not approved	
<p>9. Is the requested medication being prescribed by an allergist, immunologist, or pulmonologist?</p>	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
<p>10. Does the patient have an eosinophilic phenotype asthma as defined as either:</p> <ul style="list-style-type: none"> • 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? 	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
<p>11. Has the patient's asthma been uncontrolled despite adherence to optimized medication therapy regimen?</p> <p><i>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.</i></p>	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No STOP Coverage not approved
<p>12. 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:</p> <ul style="list-style-type: none"> • 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)? 	<input type="checkbox"/> Yes Proceed to question 22	<input type="checkbox"/> No STOP Coverage not approved
<p>13. Is the requested medication being prescribed an allergist, immunologist, pulmonologist, rheumatologist, or hematologist?</p>	<input type="checkbox"/> Yes Proceed to question 22	<input type="checkbox"/> No STOP Coverage not approved
<p>14. Is the patient 12 years of age or older?</p>	<input type="checkbox"/> Yes Proceed to question 15	<input type="checkbox"/> No STOP Coverage not approved
<p>15. Is the requested medication being prescribed an allergist, immunologist, pulmonologist, rheumatologist, or hematologist?</p>	<input type="checkbox"/> Yes Proceed to question 16	<input type="checkbox"/> No STOP Coverage not approved
<p>16. Has the patient had blood eosinophil count of GREATER than 1,000 cells/mcL in the past year?</p>	<input type="checkbox"/> Yes Proceed to question 22	<input type="checkbox"/> No STOP Coverage not approved

USFHP Prior Authorization Request Form for
mepolizumab injection (**Nucala**)

17. Is the requested medication being prescribed as add-on maintenance therapy due to patient having inadequate response to nasal corticosteroid?	<input type="checkbox"/> Yes Proceed to question 22	<input type="checkbox"/> No STOP Coverage not approved
18. Is the requested medication being prescribed by a pulmonologist?	<input type="checkbox"/> Yes Proceed to question 19	<input type="checkbox"/> No STOP Coverage not approved
19. Does the patient have moderate to severe COPD and an eosinophilic phenotype (GREATER THAN 150 cells/microliter)?	<input type="checkbox"/> Yes Proceed to question 20	<input type="checkbox"/> No STOP Coverage not approved
20. Does the patient have uncontrolled COPD symptoms despite the use of Long-Acting Muscarinic Antagonists, Long-Acting Beta-Agonist, and inhaled corticosteroids (LAMA/LABA/ICS)?	<input type="checkbox"/> Yes Proceed to question 21	<input type="checkbox"/> No STOP Coverage not approved
21. Is the requested medication being requested for add-on maintenance therapy for management of COPD?	<input type="checkbox"/> Yes Proceed to question 22	<input type="checkbox"/> No STOP Coverage not approved
22. Is the patient currently receiving another immunobiologic (for example, benralizumab [Fasenra], dupilumab [Dupixent] or omalizumab [Xolair])?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

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

Prescriber Signature

Date