FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

# Nucala® Coverage Determination Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | Office Contact: | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| | | |
|---|---|---|
| Medication Name:<br>Select one of the following:<br>❑ Request is for **GENERIC**<br>❑ Request is for **BRAND** (unable to take the generic) | Strength: | Dosage Form: |
| ❑ Check if request is for **continuation of therapy** | Directions for Use: | |

## Clinical Information (required)

**Select the Type of Coverage Determination Requested:**

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

**Select the diagnosis below:**

❑ Eosinophilic granulomatosis with polyangiitis (EGPA)

❑ Severe asthma

❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Prescriber's Specialty:**

Select if Nucala is prescribed by or in consultation with one of the following specialists:

❑ Allergy/immunology specialist

❑ Pulmonologist

**For diagnosis of Eosinophilic granulomatosis with polyangiitis (EGPA), also answer the following:**

Has the patient's disease relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy)? ❑ **Yes** ❑ **No**

Is the patient currently receiving corticosteroid therapy (e.g., prednisolone, prednisone)? ❑ **Yes** ❑ **No**

**Reauthorization:**

**For reauthorization requests, also answer the following:**

Is there documentation of a positive clinical response to therapy (e.g., increase in remission time)? ❑ **Yes** ❑ **No**

**For diagnosis of Severe Asthma, also answer the following:**

Select if there is documentation the patient has severe asthma with an eosinophilic phenotype defined by one of the following:

❑ Blood eosinophil levels are at least 150 cells/microliter at initiation of therapy

❑ Blood eosinophil levels at least 300 cells/microliter within the past 12 months

Is there documentation the patient is currently treated with high-dose inhaled corticosteroids (ICS) (e.g., greater than or equal to 500mcg fluticasone propionate equivalent/day)? ❑ **Yes** ❑ **No**

Is there documentation the patient is currently treated with an additional controller medication (e.g., long-acting beta agonist such as salmeterol or formoterol, leukotriene inhibitor such as montelukast, theophylline)? ❑ **Yes** ❑ **No**

If "no" to the above question, is there documentation the patient is intolerant of or has a contraindication to two of the additional controller agents? ❑ **Yes** ❑ **No**

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**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.