Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Nucala

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid		
□ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient at least 12 years of age?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype with absolute blood eosinophil count equal to or greater than 150 microliters (include laboratory results)?

☐ Yes ☐ No

Q3. Is the patient at least 18 years of age with a diagnosis of relapsing or refractory eosinophilic granulomatosis with polyangiitis (EGPA)? Please attach chart notes including documentation of four or more of the following criteria per the American College of Rheumatology to verify diagnosis: A. Asthma (a history of wheezing or the finding of diffuse high pitched wheezes on expiration); B. Greater than 10 percent eosinophils on the differential leukocyte count; C. Mononeuropathy (including multiplex) or polyneuropathy; D. Migratory or transient pulmonary opacities detected radiographically; E. Paranasal sinus abnormality; F. Biopsy containing a blood vessel showing the accumulation of eosinophils in extravascular areas

☐ Yes ☐ No

Q4. Is the patient currently on a stable dose of oral prednisolone or prednisone greater than or equal to 7.5 mg/day (unless contraindicated or intolerant) with or without azathioprine or methotrexate (Please attach documentation)?

☐ Yes ☐ No

Q5. Has the patient tried and failed or is intolerant to short-term treatment course of oral corticosteroids and combination therapies (such as high dose inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline)?

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☐ Yes	☐ No
Q6. Is the patient intolerant to short-term treatment course of oral corticosteroids and combination therapies (such as high dose inhaled steroids, long acting beta-agonists, antileukotrienes, theophylline) for at least for three months and has been compliant for at least three months?	
☐ Yes	☐ No
Q7. Has the patient been prescribed or recommended Nucala by a pulmonologist?	
☐ Yes	☐ No
Q8. Does the patient have asthma symptoms such as coughing, wheezing and dyspnea 2 or more days per week?	
☐ Yes	☐ No
Q9. Does the patient have use of rescue inhaler such as a short acting beta2-agonist 2 or more days per week?	
☐ Yes	☐ No
Q10. Does the patient have asthma attacks / exacerbations two or more times per week?	
☐ Yes	☐ No
Q11. Does the patient have multiple visits to the emergency room in the previous 12 months?	
☐ Yes	☐ No
Q12. Does the patient have one or more nights of nocturnal asthma causing awakening?	
☐ Yes	☐ No
Q13. Does the patient have FEV1 less than 60% of predicted normal? (Labs must be attached).	
☐ Yes	☐ No
Q14. Does the patient have reduced FEV1/FVC greater than 5%?	
☐ Yes	☐ No
Q15. Does the patient have a current parasitic (helminth) infection?	
☐ Yes	☐ No
Q16. Is the patient 50 years or older?	
☐ Yes	☐ No
Q17. Has the patient received the varicella-zoster vaccine at least 4 weeks prior to initiation of therapy?	
☐ Yes	☐ No

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Patient Name:	**Prescriber Name:**

Q18. Does the patient have a contraindication to the varicella-zoster vaccine (please submit documentation)?

☐ Yes ☐ No

Q19. Requested Duration:

☐ 6 months

Prescriber Signature _____ Date _____

Updated 2018