

# NUCALA® Refilled Autoinjector and Syringe (Mepolizumab) Prior Authorization (PA) Form

Virginia | HealthKeepers, Inc. | Anthem HealthKeepers Plus Medicaid products

If the following information is not complete, correct, or legible, the PA process could be delayed. Please use one form per member.

## Member information

Last name:

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First name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID number:

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Date of birth:

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Weight in kilograms: \_\_\_\_\_

## Prescriber information

Last name:

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First name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax number:

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## Drug information

HealthKeepers, Inc. is an independent licensee of the Blue Cross Blue Shield Association. Anthem HealthKeepers Plus, offered by HealthKeepers, Inc., is a health plan that contracts with the Virginia Department of Medical Assistance Services to provide Medicaid benefits to enrollees. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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Drug name:	_____	Drug form:	_____
Drug strength:	_____	Dosing frequency:	_____
Length of therapy:	_____	Quantity per day:	_____

The Virginia Department of Medical Assistance Services (DMAS) considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™, and Xolair® to be experimental and investigational. The safety and efficacy of these combinations have not been established and will not be permitted.

(Form continued next page.)

Member's last name:

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Member's first name:

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### Diagnosis and medical information

For severe\* asthma initial approval, complete the following questions to receive a six-month approval:

1. Is the member 6 years of age or older? AND  
 Yes     No
2. Does the member have a diagnosis of severe\* asthma? AND  
 Yes     No
3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils  $\geq 150$  cells/ $\mu$ L? AND  
 Yes     No
4. Will coadministration with another monoclonal antibody be avoided (for example, omalizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)? AND  
 Yes     No
5. Will this be used for add-on maintenance treatment in members regularly receiving both (unless otherwise contraindicated) of the following:
  - Medium- to high-dose inhaled corticosteroids, AND
  - An additional controller medication (for example, long-acting beta agonist, leukotriene modifiers) Yes     No
6. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) or one exacerbation resulting in a hospitalization? AND  
 Yes     No
7. Does the member have at least one of the following for assessment of clinical status:
  - Use of systemic corticosteroids
  - Use of inhaled corticosteroids
  - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
  - Forced expiratory volume in 1 second (FEV<sub>1</sub>) AND

Yes     No

8. Has the member tried and failed an adequate trial of the two different preferred products (Fasenra® and Xolair®)?

Yes     No

(Form continued next page.)



5. Has the physician assessed baseline disease severity utilizing an objective measure/tool (for example, Birmingham Vasculitis Activity Score (BVAS), history of asthma symptoms, and/or exacerbations, duration of remission, rate of relapses)?

Yes       No

6. Has the member tried and failed an adequate trial of the preferred product Fasenra®?

Yes       No

(Form continued next page.)



**For HES renewal, complete the following questions to receive a 12-month approval:**

1. Has the member been assessed for toxicity? AND

Yes     No

2. Does the member have disease response as indicated by a decrease in HES flares from baseline?

(Note: An HES flare is defined as worsening of clinical signs and symptoms of HES or increasing eosinophils (on at least two occasions), resulting in the need to increase oral corticosteroids or increase/add cytotoxic or immunosuppressive HES therapy.)

Yes     No

(Form continued next page.)



- Improvement in sense of smell
- Reduction of impact of comorbidities

Yes     No

(Form continued next page.)

Member's last name:

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Member's first name:

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**\* Components of severity for classifying asthma as severe may include any of the following (not all-inclusive):**

- Asthma that remains uncontrolled despite optimized treatment with high-dose ICS-LABA
- Asthma that requires high-dose ICS-LABA to prevent it from being uncontrolled
- Symptoms throughout the day
- Nighttime awakenings, often seven times/week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV<sub>1</sub>) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative to moderate asthma

**§ Eosinophilic Granulomatosis Polyangiitis (EGPA) is defined as all of the following:**

- History or presence of asthma
- Blood eosinophil level > 10% or an absolute count > 1000 cells/mm<sup>3</sup>
- Two or more of the following criteria:
  - Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil rich granulomatous inflammation
  - Neuropathy
  - Pulmonary infiltrates
  - Sinonasal abnormalities
  - Cardiomyopathy
  - Glomerulonephritis
  - Alveolar hemorrhage
  - Palpable purpura
  - Antineutrophil Cytoplasmic Antibody (ANCA) positivity

\_\_\_\_\_  
Prescriber signature (required)

\_\_\_\_\_  
Date

By signature, the physician confirms the above information is accurate and verifiable by member records. Please include all requested information; Incomplete forms will delay the

PA process. Submission of documentation does not guarantee coverage. The completed form may be faxed to 844-512-7020.



**Email is the quickest and most direct way to receive important information from us.**

To start receiving email from us (including some sent in lieu of fax or mail), submit your information using the QR code to the left or via our online form: <http://anthem.ly/signup-abcbs-va>.