OPTIMA HEALTH COMMUNITY CARE

(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: Nucala™ SQ (mepolizumab) **(J2182) (Medical)**
{Severe Eosinophilic Asthma (SEA)}

DRUG INFORMATION: Complete information below to ensure authorization will **NOT** be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

RECOMMENDED DOSAGE: 100 mg SubQ every 4 weeks

CLINICAL CRITERIA: Check **ALL** applicable boxes below to qualify. **All** Chart notes, including lab values, **MUST** be submitted with form. If **not** checked or included, authorization could be delayed.

- ❑ A diagnosis of severe eosinophilic asthma and the following criteria must be met:
  - ❑ A blood eosinophil count of at least 150 cells/microliter at the initiation of treatment

OR

  - ❑ A blood eosinophil count of at least 300 cells/microliter in the past 12 months

AND

- ❑ The patient is being followed by an allergist, immunologist, or pulmonologist

AND

- ❑ Clinical documentation that the patient is compliant with high-dose inhaled corticosteroids (ICS) and long-acting inhaled beta-2 agonists (LABA) for at least 90 days consecutively within the year of request and use of oral corticosteroids for exacerbation

AND

- ❑ Member must submit eosinophil blood count after a trial and failure of at least 90 days consecutively with high dose inhaled corticosteroids and long-acting inhaled beta-2 agonist. A failure of these medications is defined as a blood count > 150 cells/microliters **(within 8 months)**

_____

AND

(continued on next page)

- ❑ Has experienced ≥ 2 exacerbations in the previous 12 months requiring additional medical treatment **(oral corticosteroids, emergency department or urgent care visits, or hospitalizations)**

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Contact Office Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/1/2017; 6/19/18; 7/13/2018; 8/27/2018;~~ **10/8/2018**, **(Reformatted) 2/5/2019**;