OPTIMA HEALTH COMMUNITY CARE

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.***

Drug Requested: **Nucala™ SQ** (mepolizumab) **(J2182)** ***(Medical)***

DRUG INFORMATION: ***Complete information below. If incomplete, authorization process will be delayed.***

Drug Form/Strength: _____

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

Diagnosis: _____ ***ICD Code, if applicable***: _____

Recommended Dosage: ***100 mg SubQ every 4 weeks***

CLINICAL CRITERIA: ***Check ALL that apply. Chart notes, including lab values, MUST be submitted to qualify or authorization process will 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
- ❑ 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: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 8/1/2017