OPTIMA HEALTH PLAN
PHARMACY/MEDICAL PRIOR AUTHORIZATION 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 1-844-202-5034. 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)-***SEA {Severe Eosinophilic Asthma }*****(J2182)** ***(Medical)***

DRUG INFORMATION: Complete all information below or authorization will 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 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

- ❑ 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

- ❑ 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 – Briova SpecialtyRx

*****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 #: _____

***Approved by Pharmacy and Therapeutics Committee:** 3/17/2016
REVISED/UPDATED: ~~5/6/2016~~; ~~9/28/2016~~; ~~12/11/2016~~; ~~4/1/2017~~; ~~8/6/2017~~; ~~10/4/2017~~; **7/10/2018**