

OPTIMA HEALTH PLAN

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 1-844-723-2094. 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)

DRUG INFORMATION: Complete information below. Incomplete information will delay authorization process.

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 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: _____

Contact Office Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____