Trillium Health Resources
Pharmacy Prior Approval Request for

Monoclonal Antibodies: Nucala

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: **Nucala** 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (**in Days**): **Initial Request**: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days
Reauthorization Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Severe Asthma Initial Authorization:

1. Is the member 6 years of age or older? ☐ **Yes** ☐ **No**
2. Does the member have a diagnosis of severe eosinophilic asthma? ☐ **Yes** ☐ **No**
3. Does the member have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Nucala) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%? ☐ **Yes** ☐ **No** Please list eosinophil count: _____
4. Does the member have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist? ☐ **Yes** ☐ **No**
5. Does the member have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months? ☐ **Yes** ☐ **No**
Please List:_____
6. Does the member have prebronchodilator FEV1 below 80% in adults and 90% in adolescents? ☐ **Yes** ☐ **No**
Please List FEV1 value: _____
7. Is Nucala being used as add on maintenance treatment? ☐ **Yes** ☐ **No**
8. Is Nucala being used for the treatment of other eosinophilic conditions? ☐ **Yes** ☐ **No**
9. Is Nucala being used for the relief of acute bronchospasm or status asthmaticus? ☐ **Yes** ☐ **No**
10. Is Nucala being used as dual therapy with other monoclonal antibody treatments? ☐ **Yes** ☐ **No**

Severe Asthma Re-authorization (Please answer questions 1-11)
Attach Medical Documentation to this PA request form:

11. Has the member had continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the member's current asthma status and response to Nucala treatment? ☐ **Yes** ☐ **No**

Eosinophilic Granulomatosis with Polyangiitis Initial Authorization:

12. Is the member 18 years of age or older? ☐ **Yes** ☐ **No**
13. Does the member have a confirmed diagnosis of Eosinophilic Granulomatosis with Polyangiitis? ☐ **Yes** ☐ **No**

Eosinophilic Granulomatosis with Polyangiitis Re-authorization (Please answer questions 12-14)
Attach Medical Documentation to this PA request form:

14. Has the member shown clinical improvement since beginning Nucala supported by medical records? ☐ **Yes** ☐ **No**

Hypereosinophilic Syndrome (HES)

15. Is the member 12 years of age or older? ☐ **Yes** ☐ **No**
16. Does the member have a diagnosis of Hypereosinophilic Syndrome (HES) with no identifiable non-hematologic secondary cause? ☐ **Yes** ☐ **No**

Hypereosinophilic Syndrome (HES) Re-authorization (Please answer questions 15-17)
Attach Medical Documentation to this PA request form:

17. Has the member shown clinical improvement since beginning Nucala supported by medical records? ☐ **Yes** ☐ **No**

Nasal Polyps Initial Authorization:

18. Is the member 18 years of age or older? ☐ **Yes** ☐ **No**
19. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyps? ☐ **Yes** ☐ **No**
20. Has the member tried and failed monotherapy with nasal steroids? ☐ **Yes** ☐ **No**
21. Will the member continue to receive intranasal steroids concomitantly with Nucala? ☐ **Yes** ☐ **No**

Nasal Polyps Re-authorization (Please answer questions 18-22)
Attach Medical Documentation to this PA request form:

22. Has the member shown clinical improvement since beginning Nucala supported by medical records? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277