Print Reset

AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

NUCALA® Prefilled Autoinjector and Syringe (mepolizumab)

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

The Virginia Department of Medical Assistance Services considers the use of concomitant therapy with Cinqair®, Dupixent®, Fasenra®, Nucala®, Tezspire™ and Xolair® to be experimental and investigational. Safety and efficacy of theses combinations have **NOT** been established and will **NOT** be permitted.

(Form continued on next page.)

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

For severe* asthma initial approval, complete the following questions to receive a 6-month approval:

1. Is the member 6 years of age or older? **AND**

   ☐ Yes ☐ No

2. Does the member have a diagnosis of severe* asthma? **AND**

   ☐ Yes ☐ No

3. Does the member have asthma with an eosinophilic phenotype defined as blood eosinophils ≥150 cells/μL? **AND**

   ☐ Yes ☐ No

4. Will coadministration with another monoclonal antibody be avoided (e.g., omalizumab, mepolizumab, reslizumab, benralizumab, dupilumab, tezepelumab-ekko)? **AND**

   ☐ Yes ☐ No

5. Will this be used for add-on maintenance treatment in members regularly receiving **both** (unless otherwise contraindicated) of the following:
   - Medium- to high-dose inhaled corticosteroids; **AND**
   - An additional controller medication (e.g., long-acting beta agonist, leukotriene modifiers)?

   ☐ Yes ☐ No

6. Has the member had two or more exacerbations in the previous year requiring oral or injectable corticosteroid treatment (in addition to the regular maintenance therapy defined above) **or** one exacerbation resulting in a hospitalization? **AND**

   ☐ Yes ☐ No

7. Does the member have at least one of the following for assessment of clinical status:
   - Use of systemic corticosteroids
   - Use of inhaled corticosteroids
   - Number of hospitalizations, ER visits, or unscheduled visits to healthcare provider due to condition
   - Forced expiratory volume in 1 second (FEV_1)? **AND**

   ☐ Yes ☐ No

8. Has the member tried and failed an adequate trial of the 2 different preferred products (Fasenra® and Xolair®)?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | | **Member's First Name:** | | | | | | | | | | | |

For severe asthma renewal, complete the following questions to receive a 12-month approval:

9. Has the member been assessed for toxicity? **AND**

   ☐ Yes ☐ No

10. Does the member have improvement in asthma symptoms or asthma exacerbations as evidenced by decrease in one or more of the following:
    - Use of systemic corticosteroids
    - Hospitalizations
    - ER visits
    - Unscheduled visits to healthcare provider
    - Improvement from baseline in forced expiratory volume in 1 second (FEV_1)?

    ☐ Yes ☐ No

For eosinophilic granulomatosis with polyangiitis§ (EGPA) initial approval, complete the following questions to receive a 6-month approval:

11. Is the member 18 years of age or older? **AND**

    ☐ Yes ☐ No

12. Does the member have a confirmed diagnosis of EGPA (aka Churg-Strauss Syndrome)? **AND**

    ☐ Yes ☐ No

13. Does the member have blood eosinophils ≥ 150 cells/µL within 6 weeks of dosing? **AND**

    ☐ Yes ☐ No

14. Has the member been on stable doses of concomitant oral corticosteroid therapy for at least 4 weeks (i.e., prednisone or prednisolone at a dose of 7.5 mg/day)? **AND**

    ☐ Yes ☐ No

15. Has the physician assessed baseline disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS], history of asthma symptoms and/or exacerbations, duration of remission, rate of relapses)?

    ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | | **Member's First Name:** | | | | | | | | | | | |

For EGPA renewal, complete the following questions to receive a 12-month approval:

16. Has the member been assessed for toxicity? **AND**

☐ Yes ☐ No

17. Does the member have disease response as indicated by improvement in signs and symptoms compared to baseline as evidenced in one or more of the following:

- Member is in remission [defined as a Birmingham Vasculitis Activity Score (BVAS) score=0 and a prednisone/prednisolone daily dose of ≤ 7.5 mg]
- Decrease in maintenance dose of systemic corticosteroids
- Improvement in BVAS score compared to baseline
- Improvement in asthma symptoms or asthma exacerbations
- Improvement in duration of remission or decrease in the rate of relapses?

☐ Yes ☐ No

For hypereosinophilic syndrome (HES) initial approval, complete the following questions to receive a 6-month approval:

18. Is the member 12 years of age or older? **AND**

☐ Yes ☐ No

19. Has the member been diagnosed with HES (without an identifiable non-hematologic secondary cause (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy) or FIP1L1-PDGFRα kinase-positive HES) for at least 6 months prior to starting treatment? **AND**

☐ Yes ☐ No

20. Has the member had a history of 2 or more HES flares within the previous 12 months (e.g., documented HES-related worsening of clinical symptoms or blood eosinophil counts requiring an escalation in therapy)? **AND**

☐ Yes ☐ No

21. Will this be used in combination with stable doses of at least one other HES therapy, (e.g., oral corticosteroids, immunosuppressive agents, cytotoxic therapy) unless the member cannot tolerate other therapy?

☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

For HES renewal, complete the following questions to receive a 12-month approval:

22. Has the member been assessed for toxicity? **AND**

☐ Yes ☐ No

23. Does the member have disease response as indicated by a decrease in HES flares from baseline?

Note: An HES flare is defined as worsening of clinical signs and symptoms of HES or increasing eosinophils (on at least 2 occasions), resulting in the need to increase oral corticosteroids or increase/add cytotoxic or immunosuppressive HES therapy.

☐ Yes ☐ No

For chronic rhinosinusitis with nasal polyps (CRSwNP) initial approval, complete the following questions to receive a 6-month approval:

24. Is the member 18 years of age or older? **AND**

☐ Yes ☐ No

25. Does the member have bilateral symptomatic sino-nasal polyposis with symptoms lasting at least 8 weeks? **AND**

☐ Yes ☐ No

26. Has the member failed at least 8 weeks of intranasal corticosteroid therapy? **AND**

☐ Yes ☐ No

27. Will therapy be used in combination with intranasal corticosteroids unless unable to tolerate or is contraindicated? **AND**

☐ Yes ☐ No

28. Has the member tried and failed an adequate trial of the preferred product Xolair®?

☐ Yes ☐ No

For CRSwNP renewal, complete the following questions to receive a 12-month approval:

29. Has the member been assessed for toxicity? **AND**

☐ Yes ☐ No

30. Does the member have disease response as indicated by improvement in signs and symptoms compared to baseline in one or more of the following: nasal/obstruction symptoms, improvement of sinus opacifications as assessed by CT-scans and/or an improvement on a disease activity scoring tool [e.g., nasal polyposis score (NPS), nasal congestion (NC) symptom severity score, sinonasal outcome test-22 (SNOT-22), etc.]? **OR**

☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

31. Did the member have improvement in at least one of the following response criteria:
    - Reduction in nasal polyp size
    - Reduction in need for systemic corticosteroids
    - Improvement in quality of life
    - Improvement in sense of smell
    - Reduction of impact of comorbidities?

☐ Yes ☐ No

*** Components of severity for classifying asthma as *severe* may include any of the following (not all-inclusive):**

- Symptoms throughout the day
- Nighttime awakenings, often 7 times/week
- SABA use for symptom control occurs several times per day
- Extremely limited normal activities
- Lung function (percent predicted FEV_1) < 60%
- Exacerbations requiring oral systemic corticosteroids are generally more frequent and intense relative
- to moderate asthma

§ Eosinophilic Granulomatosis Polyangiitis (EGPA) is defined as all of the following:

- History or presence of asthma
- Blood eosinophil level > 10% or an absolute count > 1000 cells/mm^3
- Two or more of the following criteria:
  - Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil rich granulomatous inflammation
  - Neuropathy
  - Pulmonary infiltrates
  - Sinonasal abnormalities
  - Cardiomyopathy
  - Glomerulonephritis
  - Alveolar hemorrhage
  - Palpable purpura
  - Antineutrophil Cytoplasmic Antibody (ANCA) positivity

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.