Nucala (mepolizumab)

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:
☐ Nucala vial
☐ Nucala auto-injector
☐ Nucala syringe
☐ Other (please specify):

Directions for use: Dose: Quantity:
Duration of therapy: J-Code: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis:
☐ Asthma
☐ Atopic Dermatitis
☐ chronic obstructive pulmonary disease (COPD
☐ Eosinophilic Colitis
☐ Eosinophilic Esophagitis (EE)
☐ Eosinophilic Gastroenteritis (EG)
☐ Eosinophilic Granulomatosis with Polyangiitis (EGPA)
☐ Hypereosinophilic Syndrome
☐ Nasal Polyps
☐ *Other (please specify):*

Clinical Information

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Nucala, please choose new start of therapy. ☐ new start ☐ continued therapy

(if continued therapy, asthma) Is there documentation that the patient had a beneficial response to this medication? Examples of a beneficial response to this drug are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department/urgent care, or medical clinic visits due to asthma; and decreased requirement for oral corticosteroid therapy. ☐ Yes ☐ No

(if no) Please provide clinical support for continued use of Nucala.

(if continued therapy, EGPA) Is there documentation that the patient had a beneficial response to this medication? Examples of a beneficial response to Nucala therapy are reduced rate of relapse, corticosteroid dose reduction, and reduced eosinophil levels. ☐ Yes ☐ No

(if no) Please provide clinical support for continued use of Nucala.

(if continued therapy, if Hypereosinophilic Syndrome) Is there documentation that the patient had a beneficial response to this medication? Examples of a beneficial response to this drug are decreased number of flares, improved fatigue, reduced corticosteroid requirements, and decreased eosinophil levels. ☐ Yes ☐ No

(if no) Please provide clinical support for continued use of Nucala. .

(if continued therapy, Nasal Polyps) Has the patient continued to receive concomitant therapy with an intranasal corticosteroid? ☐ Yes ☐ No

(if continued therapy, Nasal Polyps) Is there documentation that the patient had a beneficial response to this medication? Examples of a beneficial response to this drug are reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, and/or improved sense of smell. ☐ Yes ☐ No

(if no) Please provide clinical support for continued use of Nucala.

(if asthma, EGPA, nasal polyps, or HES) Is your patient currently being treated with another antiasthmatic monoclonal antibody (for example, Cinqair, Fasenra, Nucala, Xolair)?

☐ No, not currently - OR - Yes, but this drug will be stopped when the requested drug is started
☐ Yes, and the patient will continue to use this drug with the requested drug
☐ Unknown

(if continuing use) Please provide name of drug and clinical rationale for the combined use of Nucala and another monoclonal antibody to treat your patient's diagnosis.

For Asthma:

Is this medication being prescribed by, or in consultation with, an allergist, immunologist, or a pulmonologist? ☐ Yes ☐ No

How old is the patient?

☐ 0 to 5 years of age
☐ 6 to 17 years of age (child)
☐ 18 years of age or older (adult)

(if child) Does your patient have a pre-bronchodilator FEV1 below the lower limits of normal for age (usually LESS THAN 90%) in the setting of reduced FEV1/FVC? ☐ Yes ☐ No

(if adult) Does your patient have a pre-bronchodilator FEV1 below the lower limits of normal for age (usually LESS THAN 80%) in the setting of reduced FEV1/FVC? ☐ Yes ☐ No

Does your patient have an increase of at least 12% AND 200 mL in FEV1 after the administration of 200 to 400 mcg of albuterol? ☐ Yes ☐ No

(if no) Does your patient have an increase of at least 12% AND 200 mL in FEV1 after the administration of 200 to 400 mcg of levalbuterol? ☐ Yes ☐ No

(if no) Does your patient have an increase of at least 12% AND 200 mL in FEV1 from baseline between visits or after 4 weeks of treatment? ☐ Yes ☐ No

(if no) Did the patient have a positive exercise challenge test? ☐ Yes ☐ No

(if no) Did the patient have a positive bronchial challenge test? ☐ Yes ☐ No

Does the patient have a history of blood eosinophils of 300 cells/mcl or higher? ☐ Yes ☐ No

(if no) Has the patient had blood eosinophils of 150 cells/mcl or higher within the previous 6 weeks? ☐ Yes ☐ No

(if no) Did the patient have blood eosinophils of 150 cells/mcl or higher within 6 weeks prior to treatment with any anti-interleukin-5 therapy (for example, Fasenra, Cinqair or Nucala)? ☐ Yes ☐ No

Has the patient received at least 3 consecutive months of therapy with a combination inhaler containing both an inhaled corticosteroid and a long-acting beta2-agonist? ☐ Yes ☐ No

(if no) Has the patient received at least 3 consecutive months of therapy with an inhaled corticosteroid? ☐ Yes ☐ No

(if yes) During the time the patient the inhaled corticosteroid, did the patient also receive at least 3 consecutive months of therapy with an additional asthma controller or asthma maintenance medication? ☐ Yes ☐ No
Notes: Examples of asthma controller or asthma maintenance medication include inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, leukotriene receptor antagonists, and theophylline.

At baseline, did the patient have poor symptom control as defined by an Asthma Control Questionnaire that was consistently greater than 1.5? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

(if no) At baseline, did the patient have poor symptom control as defined by an Asthma Control Test less than 20? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

(if no) At baseline, did the patient experience two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

(if no) At baseline, did the patient experience one or more asthma exacerbation(s) requiring hospitalization, an Emergency Department visit, or an urgent care visit in the previous year? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

(if no) At baseline, did the patient have asthma that required daily (or every other day) oral corticosteroids to prevent asthma exacerbations? Note: "Baseline" is defined as prior to receiving any Tezspire, anti-interleukin-5 therapies (Cinqair, Fasenra, or Nucala), Dupixent, or Xolair. ☐ Yes ☐ No

For EGPA:

Does the patient have active, non-severe disease (defined as vasculitis without life- or organ-threatening manifestations)? Examples of symptoms in individuals with non-severe disease include rhinosinusitis, asthma, mild systemic symptoms, uncomplicated cutaneous disease, mild inflammatory arthritis. ☐ Yes ☐ No

Prior to daily corticosteroid use, did the patient have an absolute eosinophil count (AEC) of 1000 cells/mcl or higher? ☐ Yes ☐ No

(if no) Prior to daily corticosteroid use, did the patient have eosinophils that were 10% or more of the total leukocytes? ☐ Yes ☐ No

(if no) Was the patient on a stable oral corticosteroid dose for at least 4 weeks? ☐ Yes ☐ No

(if yes) While on a stable oral corticosteroid dose, did the patient have an absolute eosinophil count (AEC) of 150 cells/mcl or higher? ☐ Yes ☐ No

Is this medication being prescribed by, or in consultation with, an allergist, immunologist, pulmonologist, or rheumatologist? ☐ Yes ☐ No

The covered alternative is a corticosteroid (for example, oral prednisone greater than or equal to 7.5 mg/day) for at least 4 weeks. For the alternatives tried, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?

☐ The patient tried the alternative for at least 4 weeks, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but had a significant intolerance to it.
☐ The patient can't try the alternative because of one of the following: contraindication according to the FDA label; a warning per the prescribing information (labeling); a disease characteristic or clinical factor the patient has.
☐ Other

For Hypereosinophilic Syndrome:

Has your patient had hypereosinophilic syndrome for at least 6 months? ☐ Yes ☐ No

Does your patient's disease have platelet-derived growth factor receptor - alpha gene (FIP1L1-PDGFR alpha) fusion? ☐ Yes ☐ No

Does the patient have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome (for example, drug hypersensitivity, parasitic helminth infection, human immunodeficiency virus infection, non-hematologic malignancy)? ☐ Yes ☐ No

Prior to starting therapy with any anti-interleukin-5 therapy (such as Nucala, Cinqair, Fasenra), does/did the patient have a blood eosinophil level of at least 1,000 cells per microliter? ☐ Yes ☐ No

Is the requested medication being prescribed by, or in consultation with an allergist, immunologist, pulmonologist, hematologist, or rheumatologist? ☐ Yes ☐ No

The covered alternative is at least ONE other treatment for hypereosinophilic syndrome for a minimum of 4 weeks (for example, systemic corticosteroids, hydroxyurea, cyclosporine, imatinib, methotrexate, tacrolimus, azathioprine). For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried one of the alternatives for at least 4 weeks, but it didn't work well enough.
☐ The patient is able to try at least one of these alternatives, but has not done so yet.
☐ The patient tried ALL the covered alternatives, but had a significant intolerance to each one.
☐ The patient can't try ANY of these alternatives because of one of the following: contraindication according to the FDA label; a warning per the prescribing information (labeling); a disease characteristic or clinical factor the patient has.
☐ Other

For nasal polyps:

Does your patient have evidence of chronic rhinosinusitis with nasal polyposis by direct examination, endoscopy, or sinus computed tomography (CT) scan? ☐ Yes ☐ No

Has the patient experienced any of the following symptoms for at least 6 months: i. Nasal congestion, ii. Nasal obstruction, iii. Rhinorrhea, iv. Reduction/loss of smell?
☐ Yes, all 4 of these symptoms
☐ Yes, 3 of these symptoms
☐ Yes, 2 of these symptoms
☐ Yes, 1 of these symptoms
☐ No or Unknown

Has your patient received at least 3 months of therapy with an intranasal corticosteroid? ☐ Yes ☐ No

Will your patient continue intranasal corticosteroid therapy? ☐ Yes ☐ No

Does your patient have a contraindication per FDA label to intranasal corticosteroid therapy? ☐ Yes ☐ No

Please indicate why the patient will not continue intranasal corticosteroid therapy.

Has your patient received treatment with a systemic corticosteroid within the previous two years? ☐ Yes ☐ No

Does your patient have a contraindication per FDA label to systemic corticosteroid therapy? ☐ Yes ☐ No

Has your patient had prior surgery for nasal polyps? ☐ Yes ☐ No

Is the requested medication being prescribed by, or in consultation with allergist, immunologist, or an otolaryngologist (ear, nose and throat [ENT] physician specialist)? ☐ Yes ☐ No

Additional Pertinent Information *(examples could include past medications tried, labs, pertinent patient history, and names of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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