aetna®

Nucala® (mepolizumab) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No
Group #: _____ If yes, provide ID#: _____ Carrier Name: _____
Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Pulmonologist** ☐ **Allergist** ☐ **Internal Medicine** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Nucala: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: (Clinical documentation required for all requests)

☐ Yes ☐ No Does the patient have a documented diagnosis of asthma? Please indicate the severity: ☐ Mild ☐ Moderate ☐ Severe
☐ Yes ☐ No Does the patient have clinical evidence of eosinophilic asthma phenotype?
→ Please enter the patient's eosinophil result in cells/mcL and date obtained: _____ cells/mcL Date: ____/____/____
☐ Yes ☐ No Will the patient be taking Nucala in combination with Xolair or Cinqair?

For Initial Requests:

☐ Yes ☐ No Is there documented evidence of persistent airflow obstruction?
→ **For adults**, please provide the pre-bronchodilator forced expiratory volume in 1 second (FEV1) result and date obtained:
_____ % predicted value Date obtained: ____/____/____
Please provide the patient's FEV1 reversibility result after albuterol administration: _____% _____mL
When was the reversibility test performed? Date: ____/____/____
→ **For children and adolescents,** Please provide the pre-bronchodilator forced expiratory volume in 1 second (FEV1):
_____% predicted value Date obtained: ____/____/____
Please provide the pre-bronchodilator FEV1: FVC ratio and date obtained: _____% Date: ____/____/____
Please provide the patient's FEV1 reversibility result after albuterol administration: _____ % _____mL
When was the reversibility test performed? Date: ____/____/____

☐ Yes ☐ No Is there documentation of regular use of high-dose inhaled corticosteroids (ICS)?
→ Please provide the name, dosage and date range of the inhaled corticosteroid used:
Name: _____ Dosage: _____ Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Did the patient take an oral corticosteroid in conjunction with the inhaled corticosteroid?
→ Please provide the name and date range of the oral corticosteroid used:
Name: _____ Date range: ____/____/____ to ____/____/____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

How many asthma exacerbations has the patient had in the 12 months prior to initiating Nucala? _____
Please indicate the dates of the previous exacerbations: ____/____/____, ____/____/____, ____/____/____

☐ Yes ☐ No Did the exacerbations require treatment with systemic corticosteroids (CS) (Intramuscular, intravenous, oral)?
→ Please provide route of administration: ☐ Intramuscular ☐ Intravenous ☐ Oral
Please provide the corticosteroid and dosage used to treat the exacerbations: Name: _____ Dosage: _____
Please provide the dates the systemic corticosteroids were given: ____/____/____ , ____/____/____ , ____/____/____

☐ Yes ☐ No Was the patient receiving maintenance treatment of systemic corticosteroids when the exacerbations occurred?
→ Did the patient's systemic corticosteroid dose increase for the treatment of the exacerbations?
☐ No increase ☐ Onefold increase ☐ Twofold increase

☐ Yes ☐ No Is there documentation of using high-dose ICS with an additional controller medication (e.g., long-acting beta-2-agonist (LABA), leukotriene receptor antagonist (LTRA), or theophylline)?
→ Please provide the controller medication, dose, and date range used:
Name: _____ Dosage: _____ Date range: ____/____/____ to ____/____/____

For continuation requests: (Clinical documentation required for all requests)

☐ Yes ☐ No Has the patient experienced a decrease in exacerbation frequency? **If yes,** please select which applies to the patient:
☐ No increase in inhaled corticosteroids (ICS) ☐ No increase in systemic corticosteroids (CS) ☐ None of the above

☐ Yes ☐ No Has the patient experienced a reduction in asthma signs and symptoms since starting Nucala?
→ Please indicate the symptoms that have been reduced: ☐ Chest tightness ☐ Coughing ☐ Shortness of breath ☐ Wheezing

☐ Yes ☐ No Has the patient experienced a decrease in administration of rescue medication, albuterol (salbutamol)?
→ Has the patient displayed an increase in predicted FEV1 from the pre-treatment baseline?
Please provide the **pre-treatment** baseline FEV1 result and date obtained: _____ Date: ____/____/____
Please provide the **current** FEV1 result and date obtained: _____ Date: ____/____/____

☐ Yes ☐ No Has the patient remained stable?

☐ Yes ☐ No Has the patient experienced any hypersensitivity reactions from mepolizumab (Nucala)?
→ Please indicate the reactions the patient has experienced from Nucala:
☐ Angioedema ☐ Bronchospasm ☐ Hypotension ☐ Urticaria ☐ Rash ☐ Opportunistic infections
☐ Other: please explain: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.