Nucala® (mepolizumab) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
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:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
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 ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Nucala (mepolizumab) 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):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?
→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver
→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
→ Please provide a description of the condition: ☐ Cardiovascular: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

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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.

For Initiation Requests (clinical documentation required):

Asthma

Please indicate the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count in cells per microliter: _____

☐ Yes ☐ No Does the patient have inadequate asthma control (e.g., hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimized doses: inhaled corticosteroid and additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline)?

☐ Yes ☐ No Is the patient dependent on systemic corticosteroids?

☐ Yes ☐ No Will the patient receive the requested medication as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)?

☐ Yes ☐ No Will the requested medication be used concomitantly with other biologics indicated for asthma (e.g., Fasenra, Dupixent, Xolair, or Cinqair)?

Chronic rhinosinusitis with nasal polyps (CRSwNP)

☐ Yes ☐ No Does the patient have bilateral nasal polyposis and chronic symptoms of sinusitis?

☐ Yes ☐ No Has the patient had intranasal corticosteroid treatment for at least 2 months?

→ ☐ Yes ☐ No Are intranasal corticosteroids contraindicated or not tolerated?

☐ Yes ☐ No Has the patient had prior sino-nasal surgery?

→ ☐ Yes ☐ No Has the patient had an inadequate response with systemic corticosteroids within the last two years?

→ ☐ Yes ☐ No Are systemic corticosteroids contraindicated or not tolerated?

☐ Yes ☐ No Has the patient had a bilateral nasal endoscopy or anterior rhinoscopy showing polyps reaching below the lower border of the middle turbinate or beyond in each nostril?

☐ Yes ☐ No Does the patient have nasal blockage?

☐ Yes ☐ No Does the patient have rhinorrhea (anterior/posterior), reduction or loss of smell, or facial pain or pressure?

☐ Yes ☐ No Will the patient be using a daily intranasal corticosteroid while being treated with the requested medication?

→ ☐ Yes ☐ No Are intranasal corticosteroids contraindicated or not tolerated?

Eosinophilic granulomatosis with polyangiitis (EGPA)

☐ Yes ☐ No Does the patient have a history or the presence of a blood eosinophil count greater than 1000 cells per microliter or blood eosinophil level greater than 10%?

→ Please indicate which of the following results applies to the patient:

☐ Blood eosinophil count greater than 1000 cells per microliter

☐ Blood eosinophil level greater than 10%

Please indicate which of the following additional features of EGPA are present:

☐ A biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation

☐ Neuropathy, mono or poly (motor deficit or nerve conduction abnormality)

☐ Pulmonary infiltrates, non-fixed; sino-nasal abnormality

☐ Cardiomyopathy (established by echocardiography or MRI)

☐ Glomerulonephritis (hematuria, red cell casts, proteinuria)

☐ Alveolar hemorrhage (by bronchoalveolar lavage)

☐ Palpable purpura

☐ Anti-neutrophil cytoplasmic antibody (ANCA) positive (myeloperoxidase or proteinase 3)

☐ Yes ☐ No Has the patient had at least one relapse (requiring increase in oral corticosteroids dose, initiation/increased dose of immunosuppressive therapy or hospitalization) within 2 years prior to starting treatment with the requested medication?

→ ☐ Yes ☐ No Does the patient have a refractory disease?

Hypereosinophilic syndrome (HES)

☐ Yes ☐ No Does the patient have hypereosinophilic syndrome (HES) secondary to a non-hematologic cause (e.g., drug hypersensitivity, parasitic helminth infection, [human immunodeficiency virus] HIV infection, non-hematologic malignancy)?

☐ Yes ☐ No Does the patient have FIP1L1-PDGFRA kinase-positive hypereosinophilic syndrome (HES)?

☐ Yes ☐ No Has the patient had hypereosinophilic syndrome (HES) for at least 6 months?

☐ Yes ☐ No Does the patient have a history or presence of a blood eosinophil count of at least 1000 cells per microliter?

☐ Yes ☐ No Will the patient receive the requested medication as monotherapy (i.e., without any other hypereosinophilic syndrome [HES] medications)?

☐ Yes ☐ No Is the patient on a stable dose of hypereosinophilic syndrome (HES) therapy (e.g., oral corticosteroid, immunosuppressive, and/or cytotoxic therapy)?

☐ Yes ☐ No Has the patient experienced at least two hypereosinophilic syndrome (HES) flares within the past 12 months?

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program? (Sampling of the requested medication does not guarantee coverage under the provisions of the pharmacy benefit.)

Asthma

☐ Yes ☐ No Has asthma control improved on the requested medication treatment as demonstrated by at least one of the following: a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose?

☐ Yes ☐ No Will the patient receive the requested medication as monotherapy (i.e., without any other asthma medications such as inhaled corticosteroids)?

☐ Yes ☐ No Will the patient receive the requested medication concomitantly with other biologics indicated for asthma (e.g., Fasenra, Dupixent, Xolair, or Cinqair)?

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

Chronic rhinosinusitis with nasal polyps

☐ Yes ☐ No Has the patient achieved or maintained a positive clinical response to the requested medication therapy as evidenced by improvement in signs and symptoms of chronic rhinosinusitis with nasal polyposis CRSwNP (e.g., improvement in nasal congestion, nasal polyp size, loss of smell, anterior or posterior rhinorrhea, sinonasal inflammation, hyposmia and/or facial pressure or pain or reduction in corticosteroid use)?

Eosinophilic granulomatosis and polymyositis (EGPA)

☐ Yes ☐ No Does the patient have beneficial response to treatment with the requested medication as demonstrated by any of the following: a reduction in the frequency of relapses, a reduction in the daily oral corticosteroid dose, or no active vasculitis?

Hypereosinophilic syndrome (HES)

☐ Yes ☐ No Has the patient experienced a reduction in hypereosinophilic syndrome (HES) flares since starting treatment with the requested medication?

☐ Yes ☐ No Will the patient receive the requested medication as monotherapy (i.e., without any other hypereosinophilic syndrome [HES] medications)?

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.