BlueCross BlueShield Federal Employee Program

IL-5 ANTAGONISTS (IgG1 kappa) PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Nucala (mepolizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Does the prescriber agree to assess the medical appropriateness of a varicella vaccine prior to therapy? ❑Yes ❑No
4. What is the patient's diagnosis?
   ❑ Chronic rhinosinusitis with nasal polyps (CRSwNP)
      a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of **TWO** nasal corticosteroid sprays such as mometasone, fluticasone, budesonide, or triamcinolone? ❑Yes ❑No
      b. Will this medication be used as add-on maintenance treatment? ❑Yes ❑No
      c. Will this medication be used in combination with another monoclonal antibody for the treatment of CRSwNP? ❑Yes* ❑No
         If YES, please specify the medication: _____
      d. Will the patient need more than 3 injections every 84 days? ❑Yes* ❑No
         If YES, please specify the requested quantity: _____ injections every 84 days
   ❑ Eosinophilic granulomatosis with polyangiitis (EGPA)
      a. Does the patient have an eosinophil count greater than 1000 cells per microliter (cells/mcL)? ❑Yes ❑No*
         If NO, does the patient have an eosinophil count greater than 10% of the total leukocyte count? ❑Yes ❑No
      b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to **TWO** of the following medications: systemic glucocorticoids, cyclophosphamide, azathioprine, methotrexate, or leflunomide? ❑Yes ❑No
      c. Will the patient need more than 9 injections every 84 days? ❑Yes* ❑No
         If YES, please specify the requested quantity: _____ injections every 84 days
   ❑ Hypereosinophilic syndrome (HES)
      a. Has the patient had hypereosinophilic syndrome (HES) for at least 6 months? ❑Yes ❑No
      b. Does the patient have an identifiable non-hematologic secondary cause such as drug hypersensitivity, parasitic helminth infection, HIV infection, or non-hematologic malignancy? ❑Yes ❑No
      c. Has the patient had HES flares while on stable HES therapy? ❑Yes ❑No
      d. Does the patient have an eosinophil count greater than or equal to 1000 cells per microliter (cells/mcL)? ❑Yes ❑No
      e. Will the patient need more than 9 injections every 84 days? ❑Yes* ❑No
         If YES, please specify the requested quantity: _____ injections every 84 days

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑ Severe asthma with an eosinophilic phenotype OR ❑ Severe asthma with an eosinophilic phenotype AND chronic obstructive pulmonary disease (COPD)

a. Will this medication be used for the relief of acute bronchospasm or status asthmaticus? ❑Yes ❑No

b. Has patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting beta2-agonist within the past 6 months? ❑Yes ❑No*

If NO, has patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past 6 months? ❑Yes ❑No

c. Does the patient have an eosinophil count greater than or equal 150 cells/mcL in the past 90 days? ❑Yes ❑No*

If NO, does the patient have an eosinophil count greater than or equal 300 cells/mcL in the past 12 months? ❑Yes ❑No

d. Will this medication be used as add-on maintenance treatment? ❑Yes ❑No

e. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes* ❑No

If YES, please specify the medication: _____

f. What strength is being requested? **❑40 mg ❑100 mg vial ❑100 mg subcutaneous injection**

g. Will the patient need more than 3 injections every 84 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ injections every 84 days

❑ Chronic obstructive pulmonary disease (COPD)

a. Does the patient have a diagnosis of asthma? ❑Yes* ❑No

If YES, please answer the questions under the diagnosis of **Severe Asthma AND chronic obstructive pulmonary disease (COPD)** above.

b. Will this medication be used for the emergency relief of acute bronchospasm? ❑Yes ❑No

c. Will this medication be used in combination with another monoclonal antibody for the treatment of CRSwNP? ❑Yes* ❑No

If YES, please specify the medication: _____

d. Does the patient have an eosinophil count greater than or equal to 150 cells/mcL in the past 90 days? ❑Yes ❑No*

If NO, does the patient have an eosinophil count greater than or equal to 300 cells/mcL in the past 12 months? ❑Yes ❑No

e. Does the patient have oral corticosteroid dependent COPD? ❑Yes ❑No

f. Has the patient had at least 1 month of daily oral corticosteroid use within the last 3 months? ❑Yes ❑No*

If NO, does the patient currently require oral corticosteroids? ❑Yes ❑No

g. Has the patient had 2 or more moderate COPD exacerbations in the past year? ❑Yes ❑No*

If NO, has the patient had 1 or more severe COPD exacerbations leading to hospitalization in the past year? ❑Yes ❑No

h. Has the patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a long acting beta2-agonist and a long acting muscarinic antagonist in combination with a corticosteroid inhaler within the past 6 months? ❑Yes ❑No*

If NO, does the patient have a contraindication to inhaled corticosteroids? ❑Yes* ❑No

If YES, has the patient had inadequate control of asthma symptoms after a minimum of 3 months of compliant use defined as greater than or equal to 50 percent adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past 6 months? ❑Yes ❑No

i. Will the patient need more than 3 injections every 84 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ injections every 84 days

❑ Other ***(please specify):*** _____

a. How many injections will the patient need every 84 days? _____ injections every 84 days

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Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		
PHYSICIAN COMPLETES					

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CONTINUATION OF THERAPY (PA RENEWAL)

Nucala (mepolizumab)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **4 months** excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. What is the patient's diagnosis?
   ❑Asthma with an eosinophilic phenotype OR ❑ Asthma with an eosinophilic phenotype AND chronic obstructive pulmonary disease (COPD)
   a. Will this medication be used for the relief of acute bronchospasm or status asthmaticus? ❑Yes ❑No
   b. Has the patient had a documented decrease in exacerbations **OR** improvement in symptoms? ❑Yes ❑No
   c. Has the patient decreased utilization of rescue medications? ❑Yes ❑No
   d. Has the patient been compliant on Nucala therapy? ❑Yes ❑No
   e. Will this medication be used as add-on maintenance treatment? ❑Yes ❑No
   f. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes* ❑No
   ***If YES**, please specify the medication: _____
   g. What strength is being requested? ❑**40 mg** ❑**100 mg vial** ❑**100 mg subcutaneous injection**
   h. Will the patient need more than 3 injections every 84 days? ❑Yes* ❑No
   ***If YES**, please specify the requested quantity: _____ injections every 84 days
   ❑Chronic obstructive pulmonary disease (COPD)
   a. Does the patient have a diagnosis of asthma? ❑Yes* ❑No
   ***If YES**, please answer the questions under the diagnosis of **Asthma AND chronic obstructive pulmonary disease (COPD)** above.
   b. Will this medication be used for the emergency relief of acute bronchospasm? ❑Yes ❑No
   c. Has the patient had decreased exacerbations and/or an improvement in symptoms? ❑Yes ❑No
   d. Will this medication be used in combination with another monoclonal antibody for the treatment of asthma or COPD? ❑Yes* ❑No
   ***If YES**, please specify the medication: _____
   e. Will the patient need more than 3 injections every 84 days? ❑Yes* ❑No
   ***If YES**, please specify the requested quantity: _____ injections every 84 days

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

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PAGE 4 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Chronic rhinosinusitis with nasal polyps (CRSwNP)

a. Has there been an improvement in sino-nasal symptoms? ❑Yes ❑No

b. Will this medication be used as add-on maintenance treatment? ❑Yes ❑No

c. Will this medication be used in combination with another monoclonal antibody for the treatment of CRSwNP? ❑Yes* ❑No

If YES, please specify the medication: _____

d. Will the patient need more than 3 injections every 84 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ injections every 84 days

❑ Eosinophilic granulomatosis with polyangiitis (EGPA)

a. Has the patient experienced an improvement in symptoms while on Nucala? ❑Yes ❑No

b. Will the patient need more than 9 injections every 84 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ injections every 84 days

❑ Hypereosinophilic syndrome (HES)

a. Has the patient experienced an improvement in symptoms and/or reduction in the number of flares while on Nucala? ❑Yes ❑No

b. Will the patient need more than 9 injections every 84 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ injections every 84 days

❑ Other ***(please specify):*** _____

a. How many injections will the patient need every 84 days? _____ injections every 84 days

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To ensure a quick and accurate response to your prior approval request, please **submit medical records (e.g., chart notes, laboratory values)** pertaining to the diagnosis only. Please do not send in medical records of other diagnoses in order to streamline the process. Please use this page as a **guideline** of what documentation is required to process the prior authorization request.

***For more efficient processing, please provide the page number of the documented information in the medical record**

Documentation Required for Diagnoses:

❑Asthma with an eosinophilic phenotype

- 6 years of age or older **PAGE _____ of _____**
- **NOT** used for the relief of acute bronchospasm or status asthmaticus **PAGE _____ of _____**
- Used as add-on maintenance treatment **PAGE _____ of _____**
- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Severe asthma
  - Inadequate control of symptoms after a minimum of 3 months of compliant use with **ONE** of the following within the past 6 months:
    - Inhaled corticosteroids and long acting beta$_2$ agonist **OR** Inhaled corticosteroids and long acting muscarinic antagonist
  - Eosinophil count in the past 90 days **OR** in the past 12 months
  - Assessment of the medical appropriateness for a varicella vaccination prior to therapy
- **Documentation Required for CONTINUATION of therapy: PAGE _____ of _____**
  - Decreased exacerbations **OR** improvement in symptoms
  - Decreased utilization of rescue medications
  - Compliant on Nucala therapy

❑ Chronic obstructive pulmonary disease (COPD)

- **NOT** used for the emergency relief of acute bronchospasm **PAGE _____ of _____**
- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Patient has **ONE** of the following:
    - Eosinophilic phenotype with eosinophil count in the past 90 days **OR** in the past 12 months
    - Oral corticosteroid dependent with **ONE** of the following:
      - ❖ 1 month of daily oral corticosteroid use within the last 3 months **OR** currently requires oral corticosteroids
  - Patient has **ONE** of the following:
    - 2 or more moderate COPD exacerbations in the past year **OR** 1 or more severe COPD exacerbations leading to hospitalization in the past year
  - Inadequate control of symptoms after a minimum of 3 months of compliant use with **ONE** of the following within the past 6 months **OR** a contraindication to inhaled corticosteroids:
    - long acting beta2-agonist and a long acting muscarinic antagonist in combination with a corticosteroid inhaler
    - long acting beta2-agonist and a long acting muscarinic antagonist
- **Documentation required for CONTINUATION of therapy: PAGE _____ of _____**
  - Decreased exacerbation **OR** improvement in symptoms
  - Compliant on Nucala therapy

❑Chronic rhinosinusitis with nasal polyps (CRSwNP)

- 18 years of age or older **PAGE _____ of _____**
- Used as add-on maintenance treatment **PAGE _____ of _____**
- **NO** dual therapy with another monoclonal antibody **PAGE _____ of _____**
- **Documentation required for INITIATION of therapy: PAGE _____ of _____**
  - Inadequate treatment response, intolerance, or contraindication to a 3-month trial of **TWO** nasal corticosteroid sprays: budesonide, fluticasone, mometasone, or triamcinolone
  - Assessment of the medical appropriateness for a varicella vaccination prior to therapy
- **Documentation Required for CONTINUATION of therapy: PAGE _____ of _____**
  - Improvement in sino-nasal symptoms

GUIDELINE CONTINUES ON PAGE 6

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❑**Eosinophilic granulomatosis with polyangiitis (EGPA)**

- 18 years of age or older **PAGE _____ of _____**
- **Documentation required for <u>INITIATION</u> of therapy: PAGE _____ of _____**
  - Inadequate treatment response, intolerance, or contraindication to **TWO** of the following medications: azathioprine, cyclophosphamide, leflunomide, methotrexate, or systemic glucocorticoids
  - Eosinophil count **OR** Eosinophil count of the total leukocyte count
  - Assessment of the medical appropriateness for a varicella vaccination prior to therapy
- **Documentation Required for <u>CONTINUATION</u> of therapy: PAGE _____ of _____**
  - Improvement in symptoms

❑**Hypereosinophilic syndrome (HES)**

- 12 years of age or older **PAGE _____ of _____**
- **Documentation required for <u>INITIATION</u> of therapy: PAGE _____ of _____**
  - HES syndrome for at least 6 months
  - **NO** identifiable non-hematologic secondary cause (drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy)
  - HES flares while on stable HES therapy (chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy)
  - Eosinophil count
  - Assessment of the medical appropriateness for a varicella vaccination prior to therapy
- **Documentation Required for <u>CONTINUATION</u> of therapy: PAGE _____ of _____**
  - Improvement in symptoms and/or reduction in the number of flares