OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Nucala® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Eosinophilic granulomatosis with polyangitis (EGPA)
❑ Severe eosinophilic asthma
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Nucala is prescribed by or in consultation with one of the following specialists:
❑ Allergist/Immunologist
❑ Pulmonologist
❑ Rheumatologist

For eosinophilic granulomatosis with polyangitis (EGPA), answer the following:

Has the patient's disease relapsed or is the disease refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy)? ❑ **Yes** ❑ **No**

Is the patient currently receiving corticosteroid therapy (e.g., prednisolone, prednisone)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation that the patient has had a positive clinical response to therapy (e.g., increase in remission time)? ❑ **Yes** ❑ **No**

For severe eosinophilic asthma, answer the following:

Select to confirm the asthma is an eosinophilic phenotype as defined by the following:
❑ Peripheral blood eosinophil level measured within 6 weeks of dosing is ≥ to 150 cells/microliter
❑ Peripheral blood eosinophil levels were ≥ to 300 cells/microliter within the past 12 months

Has the patient had at least two or more asthma exacerbations requiring systemic corticosteroids within the past 12 months? ❑ **Yes** ❑ **No**

Has the patient had any prior intubation for an asthma exacerbation? ❑ **Yes** ❑ **No**

Has the patient had prior asthma-related hospitalization within the past 12 months? ❑ **Yes** ❑ **No**

Select if the patient is currently being treated with, or has a contraindication, or intolerance to the following:
❑ High-dose inhaled corticosteroid (ICS) [e.g., greater than 500 mcg fluticasone propionate equivalent/day]
❑ Additional asthma controller medication [e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline]
❑ One maximally-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

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Nucala® Prior Authorization Request Form (Page 2 of 2)

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Reauthorization:

Is there documentation the patient has had a positive clinical response (e.g., reduction in exacerbations)? ❑ **Yes** ❑ **No**

Select if the patient is currently being treated with, or has a contraindication, or intolerance to the following:

- ❑ Inhaled corticosteroid (ICS)
- ❑ Additional asthma controller medication [e.g., leukotriene receptor antagonist, long-acting beta-2 agonist (LABA), theophylline)
- ❑ A combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/formoterol)]

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.