OPTUMRx®

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)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			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 polyangiitis (EGPA)
❑ Severe asthma
❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

Has the patient relapsed or is 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) unless there is a contraindication or intolerance to corticosteroid therapy? ❑ **Yes** ❑ **No**

Is Nucala prescribed by or in consultation with a pulmonologist, rheumatologist, or allergist/immunologist? ❑ **Yes** ❑ **No**

Reauthorization:

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

For severe asthma, answer the following:

Does the patient have an eosinophilic phenotype as defined by peripheral blood eosinophil level greater than or equal to 150 cells/microliter measured within 6 weeks of dosing? ❑ **Yes** ❑ **No**

Does the patient have an eosinophilic phenotype as defined by peripheral blood eosinophil level greater than or equal to 300 cells/microliter within the past 12 months? ❑ **Yes** ❑ **No**

Has the patient had at least two 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 a 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] **AND** an 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)]

Is Nucala prescribed by or in consultation with a pulmonologist or allergy/immunology specialist? ❑ **Yes** ❑ **No**

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

Is Nucala prescribed by or in consultation with a pulmonologist or allergy/immunology specialist? ❑ **Yes** ❑ **No**

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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Quantity Limit:

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
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ 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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.