



**NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Monoclonal Antibodies: Nucala**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): Initial Request: up to 30 Days 60 Days 90 Days 120 Days 180 Days
Continuation Request: up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Clinical Information

Severe Asthma Initial Authorization:

1. Is the beneficiary 6 years of age or older? Yes No
2. Does the beneficiary have a diagnosis of severe eosinophilic asthma? Yes No
3. Does the beneficiary have a pre-treatment serum eosinophil count of 150 cells/mcL, or greater, at screening (within the past six weeks prior to the request for Nucala) or 300 cells/mcL, or greater, within 12 months prior to use, or sputum eosinophilic count greater than 3%? Yes No Please list eosinophil count: _____
4. Does the beneficiary have inadequate control of asthmatic symptoms after a minimum of three months of high-dose corticosteroid inhaler in combination with a long-acting beta-agonist? Yes No
5. Does the beneficiary have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months? Yes No
Please List: _____
6. Does the beneficiary have prebronchodilator FEV1 below 80% in adults and 90% in adolescents? Yes No
Please List FEV1 value: _____
7. Is Nucala being used as an add-on maintenance treatment? Yes No
8. Is Nucala being used for the treatment of other eosinophilic conditions? Yes No
9. Is Nucala being used for the relief of acute bronchospasm or status asthmaticus? Yes No
10. Is Nucala being used as dual therapy with other monoclonal antibody treatments? Yes No

Severe Asthma Re-Authorization (Please answer questions 1-11) **Attach Medical Documentation to this PA request form:**

11. Has the beneficiary had continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Nucala treatment? Yes No

Eosinophilic Granulomatosis with Polyangiitis Initial Authorization:

12. Is the patient 18 years of age or older? Yes No
13. Does the beneficiary have a confirmed diagnosis of Eosinophilic Granulomatosis with Polyangiitis? Yes No

Eosinophilic Granulomatosis with Polyangiitis Re-authorization (Please answer questions 12-14) **Attach Medical Documentation to this PA request form:**

14. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records? Yes No

Hypereosinophilic Syndrome (HES)

15. Is the beneficiary 12 years of age or older? Yes No
16. Does the beneficiary have a diagnosis of Hypereosinophilic Syndrome (HES) with no identifiable non-hematologic secondary cause? Yes No

Hypereosinophilic Syndrome (HES) Re-authorization (Please answer questions 15-17) **Attach Medical Documentation to this PA request form:**

17. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records? Yes No

Nasal Polyps (Initial)

18. Is the beneficiary 18 years of age or older? Yes No
19. Does the beneficiary have a diagnosis of chronic rhinosinusitis with nasal polyps? Yes No
20. Has the beneficiary tried and failed monotherapy with nasal steroids? Yes No
21. Will the beneficiary continue to receive intranasal steroids concomitantly with Nucala? Yes No

Nasal Polyps (Re-authorization) (Please answer questions 18-22) **Attach Medical Documentation to this PA request form:**

22. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records? Yes No

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189**
Pharmacy PA Call Center: **1-866-799-5318**

02.06.2023