

Nucala
Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____ **NPI#:** _____
Specialty: _____ **Physician Office Fax:** _____
Physician Office Telephone: _____

Referring Provider Info: Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: Same as Referring Provider Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ kg

Patient Height: _____ cm

Please indicate the place of service for the requested drug:

- Ambulatory Surgical Home Inpatient Hospital Off Campus Outpatient Hospital
 On Campus Outpatient Hospital Office Pharmacy

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Nucala SGM – 8/2018.

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Criteria Questions:

1. What is the diagnosis?
 - Eosinophilic asthma
 - Eosinophilic granulomatosis with polyangiitis (EGPA)
 - Other _____
2. What is the ICD-10 code? _____
3. Is this a request for initial therapy or for continuation of therapy?
 - Initial therapy with Nucala, *skip to diagnosis section*
 - Continuation of therapy with Nucala
4. *If the diagnosis is eosinophilic asthma*, has asthma control improved on Nucala treatment as demonstrated by EITHER of the following?
Indicate below or mark "None of the above."
 - A reduction in the frequency or severity of symptoms and exacerbations
 - A reduction in the daily maintenance oral corticosteroid dose
 - None of the above
5. *If the diagnosis is eosinophilic granulomatosis with polyangiitis*, has the patient had a beneficial response to Nucala treatment as demonstrated by ANY of the following?
 - A reduction in the frequency of relapses
 - A reduction in the daily oral corticosteroid dose
 - No active vasculitis
 - None of the above

Section A: Eosinophilic Asthma

6. What is the patient's baseline (e.g., before significant oral steroid use) blood eosinophil count?
_____ cells per microliter
7. Does the patient have a history of severe asthma despite current treatment with BOTH of the following medications at optimized doses? Yes No
 - a) Inhaled corticosteroid
 - b) Additional controller (long acting beta₂-agonist, leukotriene modifier, or sustained-release theophylline)

Section B: Eosinophilic Granulomatosis with Polyangiitis

8. Does the patient have a history or the presence of ANY of the following?
 - Blood eosinophil count greater than 1000 cells per microliter
 - Blood eosinophil level greater than 10%
 - None of the above

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature

Date (mm/dd/yy)