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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

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*

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 $beta_2$-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)**