

**State of Oklahoma
SoonerCare
Nucala® (Mepolizumab) Prior Authorization Form**

Member Name: _____ **Date of Birth:** _____ **Member ID#:** _____
Pharmacy NPI: _____ **Pharmacy Phone:** _____ **Pharmacy Fax:** _____
Pharmacy Name: _____ **Pharmacist Name:** _____
Prescriber NPI: _____ **Prescriber Name:** _____
Specialty: _____ **Prescriber Phone:** _____ **Prescriber Fax:** _____
NDC: _____ **Dose:** _____ **Regimen:** _____ **Fill Date:** _____

Clinical Information

Compliance with all of the prior authorization criteria is a condition for payment for this drug by SoonerCare. All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval.

1. What is the diagnosis for which the medication is being prescribed?
 - Severe eosinophilic phenotype asthma
 - Other, please list: _____
2. Will this medication be used as add-on maintenance treatment for severe eosinophilic phenotype asthma?
Yes ___ No ___
3. If yes, please indicate member's daily medications and dose prescribed for the treatment of this diagnosis:
 Drug/Dose: _____ Drug/Dose: _____
 Drug/Dose: _____ Drug/Dose: _____
4. Baseline blood eosinophil count: _____ Date Determined: _____
5. Has the member been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last twelve months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist)? Yes ___ No ___
6. If yes, please include name of specialist: _____
7. Does member require daily systemic corticosteroids despite compliant use of high-dose inhaled corticosteroid (ICS) plus at least one additional controller medication? Yes ___ No ___
8. If no, please list number and dates of exacerbations requiring systemic corticosteroids within last 12 months:
Number: _____ Dates of exacerbations: _____
9. Please check all that apply:
 - Member has failed a high-dose ICS (≥ 880 mcg/day fluticasone propionate or equivalent daily dose or ≥ 440 mcg/day in ages 12 to 17) used compliantly for at least the past 12 months (for ICS/LABA combination products, the highest approved dose meets this criteria) -
Drug/Dose: _____
 - Member has failed at least one other asthma controller medication used in addition to the high-dose ICS compliantly for at least the past three months -
Drug/Dose: _____

Members must be adherent for continued approval. Initial approvals will be for the duration of six months after which time compliance will be evaluated for continued approval.

The above format is to assist the physician to provide medical documentation that SoonerCare needs to review this request.

Prescriber Signature: _____ **Date:** _____
 (By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.)

Pharmacist Signature: _____ **Date:** _____

Please do not send in chart notes. Specific information/documentation will be requested if necessary. Failure to complete this form in full will result in processing delays.

<p>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p align="center"><u>CONFIDENTIALITY NOTICE</u> <i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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