NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
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NC DHB Pharmacy Request for Prior Approval Monoclonal Antibody Therapy - Nucala

Recipient Information

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

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information: Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: **NUCALA** 10. Strength: **100mg** 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ Other: _____

Clinical Information

Severe Asthma

1. Is the beneficiary age 12 or older? ☐ Yes ☐ No
2. Does the beneficiary have a diagnosis of severe asthma with an eosinophilic phenotype? ☐ Yes ☐ No
3. Is Nucala being used in combination with a corticosteroid inhaler and long acting beta-agonist? ☐ Yes ☐ No
4. Has the beneficiary had inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler with a long acting beta-agonist? (Initial authorization requests only) ☐ Yes ☐ No
5. Is Nucala being used for treatment of any other eosinophilic condition other than severe asthma with an eosinophilic phenotype? ☐ Yes ☐ No
6. Is Nucala being used for the relief of acute bronchospasm or status asthmaticus? ☐ Yes ☐ No
7. Is Nucala being used as dual therapy with omalizumab (Xolair)? ☐ Yes ☐ No
8. Has the beneficiary had a documented response of decreased exacerbations and improvement in symptoms? (Reauthorization requests only) ☐ Yes ☐ No
9. Has the beneficiary had a decreased utilization of rescue medications since treatment with Nucala began? (Reauthorization requests only) ☐ Yes ☐ No

Eosinophilic Granulomatosis with Polyangiitis

10. Is the beneficiary age 18 or older? ☐ Yes ☐ No
11. Does the beneficiary have a confirmed diagnosis of Eosinophilic Granulomatosis with Polyangiitis? ☐ Yes ☐ No
12. Has the beneficiary shown clinical improvement since beginning Nucala? (Reauthorization requests only) ☐ Yes ☐ No

Other Diagnosis

13. Please list the diagnosis with explanation: _____
_____
_____

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

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