

Nucala (mepolizumab SC injection)

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Without this information, we may deny the request in 30 days.**

A typed and completed *General Authorization for Information form (13-835)* must be attached to your request and must be the first page (no cover sheet).

Fax to: 1-866-668-1214

DATE OF REQUEST	PATIENT	DATE OF BIRTH	PROVIDER ONE CLIENT ID
PRESCRIBER	BILLING PROVIDER NPI NUMBER	TELEPHONE NUMBER	FAX NUMBER
DRUG/STRENGTH/DOSE/FREQUENCY			
<p>1. Is patient diagnosed with severe asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the asthma diagnosis the eosinophilic phenotype? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what is patient's diagnosis? _____</p> <p>2. Has patient had at least one of the following: In the past 6 weeks: • Blood eosinophil count \geq 150 cells/μL? <input type="checkbox"/> Yes <input type="checkbox"/> No In the past 12 months: • Blood eosinophil count \geq 300 cells/μL? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is patient using a high-dose inhaled corticosteroid and additional controllers? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: • Which inhaled corticosteroid and strength was used: _____ • Did patient remain symptomatic after 2-6 weeks of regular use? <input type="checkbox"/> Yes <input type="checkbox"/> No • Has patient had 2 or more exacerbations in past 12 months despite regular use? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Has patient been vaccinated against varicella zoster virus (shingles)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide a reason: _____</p> <p>5. Will patient be taking Xolair (omalizumab) or Cinqair (reslizumab) concurrently with Nucala (mepolizumab)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
For patients who have already been taking Nucala (mepolizumab):			
Did patient demonstrate improvement while receiving Nucala (mepolizumab) by: <ul style="list-style-type: none"> Decreased use of rescue medications? <input type="checkbox"/> Yes <input type="checkbox"/> No Decreased frequency of exacerbations? <input type="checkbox"/> Yes <input type="checkbox"/> No Increased FEV1% to at least 70% predicted FEV1%? <input type="checkbox"/> Yes <input type="checkbox"/> No Did patient show any signs of anaphylaxis during treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
CHART NOTES ARE REQUIRED WITH THIS REQUEST			
PRESCRIBER'S SIGNATURE	PRESCRIBER'S SPECIALTY	DATE	