NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Monoclonal Antibodies: Nucala

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): Initial Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Continuation Request: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

Severe Asthma Initial Authorization:
1. Is the beneficiary 6 years of age or older? ☐ **Yes** ☐ **No**
2. Does the beneficiary have a diagnosis of severe eosinophilic asthma? ☐ **Yes** ☐ **No**
3. Does the beneficiary have a pre-treatment serum eosinophil count of 150 cells/mcL or greater at screening (within the past six weeks prior to the request for Nucala) or 300 cells/mcL or greater within 12 months prior to use, or sputum eosinophilic count greater than 3%? ☐ **Yes** ☐ **No** Please list eosinophil count: _____
4. Does the beneficiary have inadequate control of asthmatic symptoms after a minimum of 3 months of high dose corticosteroid inhaler in combination with a long acting beta-agonist? ☐ **Yes** ☐ **No**
5. Does the beneficiary have inadequately controlled severe asthma with two or more asthma exacerbations requiring oral/systemic corticosteroids treatment or with hospitalization in the past 12 months? ☐ **Yes** ☐ **No**
   Please List:_____
6. Does the beneficiary have prebronchodilator FEV1 below 80% in adults and 90% in adolescents? ☐ **Yes** ☐ **No**
   Please List FEV1 value: _____
7. Is Nucala being used as add on maintenance treatment? ☐ **Yes** ☐ **No**
8. Is Nucala being used for the treatment of other eosinophilic conditions? ☐ **Yes** ☐ **No**
9. Is Nucala being used for the relief of acute bronchospasm or status asthmaticus? ☐ **Yes** ☐ **No**
10. Is Nucala being used as dual therapy with other monoclonal antibody treatments? ☐ **Yes** ☐ **No**

Severe Asthma Re-authorization (Please answer questions 1-11) **Attach Medical Documentation to this PA request form****:
11. Has the beneficiary had continued clinical benefit as evidenced by reductions in asthma exacerbations from baseline supported by medical records documenting the beneficiary's current asthma status and response to Nucala treatment? ☐ **Yes** ☐ **No**

Eosinophilic Granulomatosis with Polyangiitis Initial Authorization:
12. Is the patient 18 years of age or older? ☐ **Yes** ☐ **No**
13. Does the beneficiary have a confirmed diagnosis of Eosinophilic Granulomatosis with Polyangiitis? ☐ **Yes** ☐ **No**

Eosinophilic Granulomatosis with Polyangiitis Re-authorization (Please answer questions 12-14) **Attach Medical Documentation to this PA request form****:
14. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records? ☐ **Yes** ☐ **No**

Hypereosinophilic Syndrome (HES)
15. Is the beneficiary 12 years of age or older? ☐ **Yes** ☐ **No**
16. Does the beneficiary have a diagnosis of Hypereosinophilic Syndrome (HES) with no identifiable non-hematologic secondary cause? ☐ **Yes** ☐ **No**

Hypereosinophilic Syndrome (HES) Re-authorization (Please answer questions 15-17) **Attach Medical Documentation to this PA request form****:
17. Has the beneficiary shown clinical improvement since beginning Nucala supported by medical records? ☐ **Yes** ☐ **No**

Signature of Prescriber:_____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.