AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Mepolizumab (Nucala)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for mepolizumab (Nucala). Requests will not be considered with concurrent use of omalizumab. Payment will be considered under the following conditions: 1) Patient is 12 years of age or older; and 2) Patient has a diagnosis of severe asthma with an eosinophilic phenotype; and 3) Patient has a pretreatment blood eosinophil count of ≥150 cells per mcL within the previous six weeks or blood eosinophils of ≥300 cells per mcL within 12 months prior to initiation of therapy; and 4) Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of three consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and 5) Patient has a history of two or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and 6) A pretreatment forced expiratory volume in one second (FEV1) <80% predicted; and 7) Prescriber is an allergist, immunologist, or pulmonologist; and 8) Medication is to be administered by a healthcare professional in the member's home by home health or in a long-term care facility.

If the criteria for coverage are met, an initial authorization will be given for three months to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered if one or more of the following criteria are met: 1) Patient continues to receive therapy with an ICS, LABA, and LTRA; and 2) Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or 3) Patient has experienced a decrease in administration of rescue medication (albuterol); or 4) Patient has experienced a decrease in exacerbation frequency; or 5) Patient has experienced an increase in predicted FEV1 from the pretreatment baseline. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult **www.iowamedicaidpdl.com/pa_criteria**.

Non-Preferred

☐ Nucala

Dosage Instructions:

Strength: Dosage Form: Quantity: Days Supply:

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Diagnosis:

Pretreatment blood eosinophil count (attach lab): Date obtained:

or

Blood eosinophil count obtained within 12 months prior to initiation of treatment (attach lab): Date obtained:

Pretreatment Baseline ppFEV$_1$: Date obtained:

Document current use of:

High-dose inhaled corticosteroid

Drug name: Strength:

Dosing instructions: Trial start date:

Long-Acting Beta2-Agonist

Drug name: Strength:

Dosing instructions: Trial start date:

Leukotriene Receptor Antagonist

Drug name: Strength:

Dosing instructions: Trial start date:

Does patient have a history of two or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA?: ☐ No ☐ Yes (provide dates):

Prescriber's specialty: ☐ Allergist ☐ Immunologist ☐ Pulmonologist ☐ Other:

Setting to be administered: ☐ Member's home by home health ☐ Long-term care facility ☐ Other:

Will the patient be taking omalizumab in combination with mepolizumab? ☐ No ☐ Yes

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For Renewals Only:

Does patient continue to receive therapy with an ICS, LABA, and LTRA? ☐ No ☐ Yes

Please indicate if the patient has experienced any of the following (check all that apply):

☐ Reduction in asthma signs and symptoms including:

- Wheezing
- Chest tightness
- Coughing
- Shortness of breath

☐ Decrease in administration of rescue medications (albuterol)

☐ Decrease in exacerbation frequency

☐ Increase in ppFEV1 from the pretreatment baseline Current ppFEV1:

Date obtained:

Please describe:

Medical or contraindication reason to override trial requirements:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.	
Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/provider to confirm your version of this form.