Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Netwo of Michigan

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This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Nucala**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with question set.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Site of Care:

At what location will the member be receiving the requested medication?

❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.

❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting. _____

_____

❑ Other. Please specify. _____

Criteria Questions:

1. Has the patient been on Nucala continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **Continuation Section**
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the questions below:

2. Will Nucala be used in combination with another monoclonal antibody for the treatment of the requested indication? ❑Yes* ❑No
   ***If YES**, specify the medication: _____

3. Does the prescriber agree to assess the medical appropriateness of a varicella vaccine prior to therapy? ❑Yes ❑No

4. Will Nucala be used for the relief of acute bronchospasm or status asthmaticus? ❑Yes ❑No

5. What is the patient's diagnosis?
   - ❑ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
     a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a three-month trial of **TWO** nasal corticosteroid sprays such as mometasone, fluticasone, budesonide, or triamcinolone? ❑Yes ❑No
     b. Will Nucala be used as add-on maintenance treatment? ❑Yes ❑No
   - ❑ Eosinophilic Granulomatosis with Polyangiitis (EGPA)
     a. Does the patient have an eosinophil count greater than 1000 cells per microliter (cells/mcL)? ❑Yes ❑No*
     ***If NO**, does the patient have an eosinophil count greater than 10% of the total leukocyte count? ❑Yes ❑No
     b. Does the patient have an intolerance or contraindication or have they had an inadequate response to **TWO** of the following medications: systemic glucocorticoids, cyclophosphamide, azathioprine, methotrexate, or leflunomide? ❑Yes ❑No
   - ❑ Hypereosinophilic Syndrome (HES)
     a. Has the patient had hypereosinophilic syndrome for at least six months? ❑Yes ❑No
     b. Does the patient have an identifiable non-hematologic secondary cause such as drug hypersensitivity, parasitic helminth infection, HIV infection, or non-hematologic malignancy? ❑Yes ❑No
     c. Has the patient had HES flares while on stable HES therapy? ❑Yes ❑No
     d. Does the patient have an eosinophil count greater than or equal to 1000 cells per microliter (cells/mcL)? ❑Yes ❑No
   - ❑ Severe asthma with an eosinophilic phenotype
     a. Has the patient had inadequate control of asthma symptoms after a minimum of three months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting beta$_2$-agonist within the past six months? ❑Yes ❑No*
     ***If NO**, has the patient had inadequate control of asthma symptoms after a minimum of three months of compliant use defined as greater than or equal to 50% adherence with a corticosteroid inhaler in combination with a long acting muscarinic antagonist within the past six months? ❑Yes ❑No
     b. Does the patient have an eosinophil count greater than or equal 150 cells/mcL in the past 90 days? ❑Yes ❑No*
     ***If NO**, does the patient have an eosinophil count greater than or equal 300 cells/mcL in the past 12 months? ❑Yes ❑No
     c. **6-11 Years of Age** Is this request for Nucala vials or syringes? ❑Vials* **OR** ❑Syringes
     ***If Vials**, will the patient be dosed within the FDA labeled maintenance dosing of 40mg subcutaneously every four weeks? ❑Yes ❑No
   - ❑ Other diagnosis ***(please specify):*** _____

CONTINUATION OF THERAPY (PA RENEWAL)
Nucala (mepolizumab)

1. Has the patient been on Nucala continuously for the last **4 months**, excluding samples? ***Please select answer below:***
   - ❑ **NO** – this is **INITIATION** of therapy, please answer the questions on **Initiation Section**
   - ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. What is the patient's diagnosis?
   - ❑ Asthma with an eosinophilic phenotype
     a. Has the patient had a documented decrease in exacerbations and an improvement in symptoms? ❑Yes ❑No
     b. Has the patient decreased utilization of rescue medications? ❑Yes ❑No
     c. Has the patient been compliant on Nucala therapy? ❑Yes ❑No
     d. **6-11 Years of Age** Is this request for Nucala vials or syringes? ❑Vials* **OR** ❑Syringes
     If Vials, will the patient be dosed within the FDA labeled maintenance dosing of 40mg subcutaneously every four weeks? ❑Yes ❑No
   - ❑ Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
     a. Has there been an improvement in sino-nasal symptoms? ❑Yes ❑No
     b. Will Nucala be used as add-on maintenance treatment? ❑Yes ❑No
   - ❑ Eosinophilic Granulomatosis with Polyangiitis (EGPA)
     a. Has the patient experienced an improvement in symptoms while on Nucala? ❑Yes ❑No
   - ❑ Hypereosinophilic Syndrome (HES)
     a. Has the patient experienced an improvement in symptoms and/or reduction in the number of flares while on Nucala? ❑Yes ❑No
   - ❑ Other diagnosis ***(please specify):*** _____
3. Will Nucala be used in combination with another monoclonal antibody for the treatment of the requested indication? ❑Yes* ❑No
   If YES, specify the medication: _____
4. Will Nucala be used for the relief of acute bronchospasm or status asthmaticus? ❑Yes ❑No

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	Physician Signature	Date
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**