Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Nucala
(mepolizumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication Requested:
☐ Nucala vial
☐ Nucala auto-injector
☐ Nucala syringe
☐ Other (please specify):

Directions for use: Dose: Quantity:
Duration of therapy: J-Code: ICD10:

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

*****Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:

Address (City, State, Zip Code):

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis:
☐ Asthma
☐ Atopic Dermatitis
☐ chronic obstructive pulmonary disease (COPD
☐ Chronic Rhinosinusitis with Nasal Polyps
☐ Eosinophilic Colitis
☐ Eosinophilic Esophagitis (EE)
☐ Eosinophilic Gastroenteritis (EG)
☐ Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome]
☐ Hypereosinophilic Syndrome
☐ *Other (please specify):*

Clinical Information

Will your patient use this medication with another Monoclonal Antibody Therapy? Note: Monoclonal antibody therapies are Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous injection), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto), Teszpire (tezepelumab-ekko subcutaneous injection), or Xolair (omalizumab subcutaneous injection). ☐ Yes ☐ No

(if yes) Please provide the rationale for concurrent use.

<u>If Asthma</u>

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving Nucala for at least 6 months?
☐ Initial therapy
☐ Currently receiving Nucala for at least 6 months
☐ Restarting therapy with Nucala
☐ None of the above

(if Currently receiving Nucala) Has the patient responded to therapy according to the prescriber? Note: Examples of a response to Nucala therapy are decreased asthma exacerbations; decreased asthma symptoms; decreased hospitalizations, emergency department, urgent care, or medical clinic visits due to asthma; and decreased requirement for oral corticosteroid therapy. ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if Currently receiving Nucala) Does the patient continue to receive therapy with one inhaled corticosteroid OR one inhaled corticosteroid-containing combination inhaler? ☐ Yes ☐ No

(if initial) Does your patient have a blood eosinophil level at least 150 cells per microliter within the previous 6 weeks -or- a blood eosinophil level at least 150 cells per microliter prior to treatment with Nucala or another monoclonal antibody therapy that may alter blood eosinophil levels? Note: Examples of monoclonal antibody therapies that may alter blood eosinophil levels include Nucala, Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection). ☐ Yes ☐ No

(if initial) Has the patient received at least 3 consecutive months of combination therapy with BOTH: A. An inhaled corticosteroid (medium- or high- dose); AND B. At least one additional asthma controller or asthma maintenance medication? Note: Examples of additional asthma controller or asthma maintenance medications are inhaled long-acting beta2-agonists, inhaled long-acting muscarinic antagonists, and monoclonal antibody therapies for asthma (for example, Cinqair, Dupixent, Fasenra, Nucala, Tezspire, Xolair). Use of a combination inhaler containing both an inhaled corticosteroid (medium- or high- dose) and additional asthma controller/maintenance medication(s) would fulfill the requirement for both criteria A and B. ☐ Yes ☐ No

(if initial) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year? Note: 'Baseline' is defined as prior to receiving Nucala or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Nucala, Cinqair, Dupixent, Fasenra, Tezspire, and Xolair. ☐ Yes ☐ No

(if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by the patient experiencing one or more asthma exacerbation(s) requiring hospitalization, an Emergency Department visit, or an urgent care visit in the previous year? Note: 'Baseline' is defined as prior to receiving Nucala or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Nucala, Cinqair, Dupixent, Fasenra, Tezspire, and Xolair. ☐ Yes ☐ No

(if no) Does the patient have asthma that is uncontrolled or was uncontrolled at baseline as defined by asthma that worsens upon tapering of oral (systemic) corticosteroid therapy? Note: 'Baseline' is defined as prior to receiving Nucala or another monoclonal antibody therapy for asthma. Examples of monoclonal antibody therapies for asthma include Nucala, Cinqair, Dupixent, Fasenra, Tezspire, and Xolair. ☐ Yes ☐ No

(if initial) Is this medication being prescribed by, or in consultation with, an allergist, immunologist, or pulmonologist? ☐ Yes ☐ No

if 12 years of age or older

(if initial) Does the patient have a forced expiratory volume in 1 second (FEV1) less than 80% predicted that is NOT due to smoking-related chronic obstructive pulmonary disease? ☐ Yes ☐ No

(if yes) Does the patient have an FEV1/forced vital capacity (FVC) less than 0.80? ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% AND greater than 200ml in FEV1 following administration of a standard dose of a short-acting bronchodilator? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% AND greater than 200ml in FEV1 between prescriber visits? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% AND greater than 200ml in FEV1 from baseline to after at least 4 weeks of asthma treatment? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Did the patient have a positive exercise challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Did the patient have a positive bronchial challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

if less than 12 years old

(if initial) Does the patient have a forced expiratory volume in 1 second (FEV1) less than 80% predicted that is NOT due to smoking-related chronic obstructive pulmonary disease? ☐ Yes ☐ No

(if yes) Does the patient have an FEV1/forced vital capacity (FVC) less than 0.80? ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% in FEV1 following administration of a standard dose of a short-acting bronchodilator? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% in FEV1 between prescriber visits? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Does the patient have an increase of over 12% in FEV1 from baseline to after at least 4 weeks of asthma treatment? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Did the patient have a positive exercise challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

(if no) Did the patient have a positive bronchial challenge test? Note: The above lung function criteria may be met at any time prior to or during asthma treatment. ☐ Yes ☐ No

<u>If Chronic Rhinosinusitis with Nasal Polyps</u>

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving Nucala for at least 6 months?
☐ Initial therapy
☐ Currently receiving Nucala for at least 6 months
☐ Restarting therapy with Nucala
☐ None of the above

(if Currently receiving Nucala) Does the patient continue to receive therapy with an intranasal corticosteroid? ☐ Yes ☐ No

(if Currently receiving Nucala) Has the patient responded to therapy according to the prescriber? Note: Examples of a response to Nucala therapy are reduced nasal polyp size, improved nasal congestion, reduced sinus opacification, decreased sino-nasal symptoms, improved sense of smell. ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if initial) Does your patient have chronic rhinosinusitis with nasal polyps as proven by direct examination, endoscopy, or sinus computed tomography (CT) scan? ☐ Yes ☐ No

(if initial) Has the patient experienced any of the following symptoms for at least 6 months: i. Nasal congestion; ii. Nasal obstruction; iii. Nasal discharge, and/or iv. Reduction/loss of smell?
☐ Yes, all 4 of these symptoms
☐ Yes, 3 of these symptoms
☐ Yes, 2 of these symptoms
☐ Yes, 1 of these symptoms
☐ No

(if initial) Has your patient received at least 4 weeks of therapy with an intranasal corticosteroid? ☐ Yes ☐ No

((if yes) Will your patient continue to receive therapy with an intranasal corticosteroid concomitantly with Nucala? ☐ Yes ☐ No

(if initial) Has your patient received at least one course of treatment with a systemic corticosteroid for 5 days or more within the previous 2 years? ☐ Yes ☐ No

(if no) Does your patient have a contraindication to systemic corticosteroid therapy? ☐ Yes ☐ No

(if no) Has your patient had prior surgery for nasal polyps? ☐ Yes ☐ No

(if initial) Is the requested medication being prescribed by (or in consultation with) an allergist, immunologist, or an otolaryngologist (ear, nose and throat [ENT] physician specialist)? ☐ Yes ☐ No

If Eosinophilic Granulomatosis with Polyangiitis (EGPA) [formerly known as Churg-Strauss Syndrome]

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving Nucala for at least 6 months?
☐ Initial therapy
☐ Currently receiving Nucala for at least 6 months
☐ Restarting therapy with Nucala
☐ None of the above

(if Currently receiving Nucala) Has the patient responded to therapy according to the prescriber? Note: Examples of a response to Nucala therapy are reduced rate of relapse, corticosteroid dose reduction, and reduced eosinophil levels. ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if initial) Does the patient have active, non-severe disease? Note: Non-severe disease is defined as vasculitis without life- or organ-threatening manifestations. Examples of symptoms in patients with non-severe disease include rhinosinusitis, asthma, mild systemic symptoms, uncomplicated cutaneous disease, mild inflammatory arthritis. ☐ Yes ☐ No

(if initial) Does your patient have a blood eosinophil level at least 150 cells per microliter within the previous 4 weeks or a blood eosinophil level at least 150 cells per microliter prior to treatment with Nucala or another monoclonal antibody therapy that may alter blood eosinophil levels? Note: Examples of monoclonal antibody therapies that may alter blood eosinophil levels include Nucala, Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz subcutaneous injection), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection). ☐ Yes ☐ No

(if initial) Is your patient currently receiving a systemic corticosteroid (for example, prednisone) for a minimum of 4 weeks? ☐ Yes ☐ No

(if initial) Is the requested medication being prescribed by (or in consultation with) an allergist, immunologist, pulmonologist, or rheumatologist? ☐ Yes ☐ No

If Hypereosinophilic Syndrome

Is this initial therapy, is the patient restarting therapy, or is the patient currently receiving Nucala for at least 8 months?
☐ Initial therapy
☐ Currently receiving Nucala for at least 8 months
☐ Restarting therapy with Nucala
☐ None of the above

(if Currently receiving Nucala) Has the patient responded to therapy according to the prescriber? Note: Examples of a response to Nucala therapy are decreased number of flares, improved fatigue, reduced corticosteroid requirements, and decreased eosinophil levels. ☐ Yes ☐ No

(if no) Please provide support for continued use.

(if initial) Has your patient had hypereosinophilic syndrome for at least 6 months? ☐ Yes ☐ No

(if initial) Does your patient have FIP1L1-PDGFR alpha-negative disease? ☐ Yes ☐ No

(if initial) Does the patient have an identifiable non-hematologic secondary cause of hypereosinophilic syndrome? Note: Examples of secondary causes of hypereosinophilic syndrome include drug hypersensitivity, parasitic helminth infection, human immunodeficiency virus infection, non-hematologic malignancy. ☐ Yes ☐ No

(if initial) Does/did your patient have a blood eosinophil level at least 1,000 cells per microliter prior to treatment with any monoclonal antibody therapy that may alter blood eosinophil levels? Note: Examples of monoclonal antibody therapies that may alter blood eosinophil levels include Nucala, Adbry (tralokinumab-ldrm subcutaneous injection), Cinqair (reslizumab intravenous infusion), Dupixent (dupilumab subcutaneous injection), Ebglyss (lebrikizumab-lbkz), Fasenra (benralizumab subcutaneous injection), Nemluvio (nemolizumab-ilto), Tezspire (tezepelumab-ekko subcutaneous injection), and Xolair (omalizumab subcutaneous injection). ☐ Yes ☐ No

(if initial) Has your patient tried at least one other treatment for hypereosinophilic syndrome for a minimum of 4 weeks? Note: Example of treatments for hypereosinophilic syndrome include systemic corticosteroids, hydroxyurea, cyclosporine, imatinib, or pegylated-interferon. ☐ Yes ☐ No

(if Hypereosinophilic, if initial) Is the requested medication being prescribed by (or in consultation with) an allergist, immunologist, pulmonologist, or rheumatologist? ☐ Yes ☐ No

Additional Pertinent Information *(examples could include past medications tried, labs, pertinent patient history, and names of any agents to be used concurrently):*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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