



Prior Authorization Request Form Nucala (mepolizumab)



****SENSITIVE BUT UNCLASSIFIED****

This form is to be completed and signed by the CCE/NPN Medical Director and should only be used for prescriptions to be filled through the World Trade Center Health Program (WTCHP).

The CCE/NPN should upload this completed form into VitalPoint and inform the PBM and the WTCHP of this request via the SAMS messaging system.

Please provide the following member and prescriber information (please print):

Member Name: _____	Prescriber Name: _____
Member ID: _____	Prescriber Address: _____
CCE/NPN: _____	_____
Requested Medication: _____	Prescriber Phone #: _____

Please complete the following clinical assessment:

- | | | |
|---|-----------------------------------|-------------------------------------|
| 1. Does member have severe and uncontrolled asthma? | Yes
Go to question 2 | No
Medication not covered |
| 2. Have results of complete blood count (CBC) shown eosinophils of at least 150 cells/microliter at the initiation of treatment or eosinophils of at least 300 cells/microliter in the past 12 months? | Yes
Go to question 3 | No
Medication not covered |
| 3. Has the member had an adequate trial and been adherent to a regimen that includes high-dose inhaled corticosteroids (e.g., Flovent®, Pulmicort™), with or without oral corticosteroids, in combination with any of the following additional controllers?
<ul style="list-style-type: none"> a. Long-acting beta agonist (Performomist™, Serevent®) b. Leukotriene inhibitor (Singulair®) c. Theophylline | Yes
Sign and date below | No
Medication not covered |

OR

Member is intolerant or has contraindications to these agents.

**TO BE FILLED OUT BY
WTC HEALTH PROGRAM**

Decision:

Decision Comments:

By signing below, I certify that the above information is correct and accurate to the best of my knowledge.

_____	_____
WTCHP (NIOSH) Signature	Date
_____	_____
CCE/NPN Medical Director (or Designee) Signature	Date

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