# 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: _____

Member ID: _____

CCE/NPN: _____

Requested Medication: _____

Prescriber Name: _____

Prescriber Address: _____

_____

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?

☐ Yes **Sign and date below**

☐ No **Medication not covered**

a. Long-acting beta agonist (Performomist™, Serevent®)
b. Leukotriene inhibitor (Singulair®)
c. Theophylline

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

Additional information may be attached to this document if needed.

Effective 5/9/2018

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