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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