VERMONT

Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Nucala~

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must fax this form to Change Healthcare. Please complete this form in its entirety, and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare Helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Patient's Phone: _____
Pharmacy Name: _____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:
HCPCS J-code or other code: _____
Administering Provider/Facility: Name_____ NPI#_____ Medicaid ID#_____

Dose: _____ Frequency: _____Formulation: ☐ auto-injector pen
☐ vial ☐ prefilled syringe

* For approval of Nucala vial or prefilled syringe, the patient must be unable to use the auto-injector

Please select diagnosis/indication for use and complete corresponding section of PA form.
*Clinical documentation must be submitted to support information on PA form

☐ **Severe Persistent Asthma** ☐ **Eosinophilic Granulomatosis with Polyangiitis** ☐ **Hypereosinophilic Syndrome (HES)**

☐ **Chronic Rhinosinusitis with Nasal Polyps**

Severe Persistent Asthma

- Is the member currently smoking? **NO** ☐ **YES** ☐ Quit Date (if applicable) _____
- Is the prescriber an allergist, immunologist, or pulmonologist: **NO** ☐ **YES** ☐
- ICS/LABA combination product trialed for a minimum of 3 consecutive months:

Specific Drug:	**Response to therapy:**	**Dates of use:**
_____	_____	_____
_____	_____	_____

- Does the patient have uncontrolled asthma symptoms (symptoms occurring almost daily or waking at night with asthma at least one a week): **NO** ☐ **YES** ☐ Number of daytime symptom occurrences per week: _____
  Number of nighttime symptom occurrences per week: _____
- Has the patient had 2 or more exacerbations in the previous year despite use of medium-high dose ICS/LABA: **NO** ☐ **YES** ☐
- Eosinophilic phenotype as defined by pre-treatment blood eosinophil count: **NO** ☐ **YES** ☐
  Eosinophil Count: _____Date obtained: _____

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Renewal Requests for Severe Persistent Asthma

(Clinical notes documenting member's response to therapy must be submitted):

- Has the patient continued to receive therapy with an ICS/LABA? **NO** ☐ **YES** ☐
- Does the patient have documented improvement in FEV1 from baseline? **NO** ☐ **YES** ☐
- Does the patient have a decreased frequency of exacerbations? **NO** ☐ **YES** ☐
- Is there documented evidence of a decreased dose/frequency of oral corticosteroid requirements? **NO** ☐ **YES** ☐
- Is there documented evidence of a decreased dose/frequency of rescue medications? **NO** ☐ **YES** ☐
- Is there a reduction in the signs and symptoms of asthma? **NO** ☐ **YES** ☐
  Number of daytime symptom occurrences per week: _____
  Number of nighttime symptom occurrences per week: _____

Eosinophilic Granulomatosis with Polyangiitis

- Has the patient trialed any medications for this indication? **NO** ☐ **YES** ☐

Specific Drug:	Reason for discontinuation:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Eosinophil Count: _____Date obtained: _____
- Renewal requests for Eosinophilic Granulomatosis with Polyangiitis: please include clinical notes documenting response to therapy

Hypereosinophilic Syndrome (HES)

- Is the prescriber an allergist, hematologist, immunologist, or pulmonologist: **NO** ☐ **YES** ☐
- Eosinophil Count: _____Date obtained: _____
- Has the patient had at least 2 HES flares within the past 12 months? **NO** ☐ **YES** ☐
- Is the patient on a stable dose of background HES therapy (chronic or episodic corticosteroids, immunosuppressive, or cytotoxic therapy for at least 4 weeks)? **NO** ☐ **YES** ☐

Specific Drug:	Dates of use:
_____	_____
_____	_____

- Renewal requests for Hypereosinophilic Syndrome: please include clinical notes documenting response to therapy

Chronic Rhinosinusitis with Nasal Polyps

- Is the prescriber an allergist or ENT Specialist: **NO** ☐ **YES** ☐
- Has the patient had at least a 3 month trial of 2 different nasal corticosteroids? **NO** ☐ **YES** ☐

Specific Drug:	Reason for discontinuation:	Date:
_____	_____	_____
_____	_____	_____

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- Has the patient had a trial of at least a 10-14 day course of oral corticosteroids? **NO** ☐ **YES** ☐
- Will the patient continue therapy with an intranasal corticosteroid? **NO** ☐ **YES** ☐
- Renewal requests for Chronic Rhinosinusitis with Nasal Polyps: the patient must continue to receive therapy with an intranasal corticosteroid AND there must be documented improvement in nasal symptoms (please include clinical notes documenting response to therapy)

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber's Signature: Date:

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