



**Outpatient Medical Injectable
Monoclonal Antibodies for the Treatment of
Asthma and Eosinophilic Conditions
Request Form
Fax to 833-581-1861
(Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member ID (UMI): _____ Medicare Commercial*

Ordering/Attending Provider Name: _____ NPI: _____

Ordering/Attending Provider Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Servicing Facility/Vendor Name: _____ Facility NPI: _____

Servicing Facility/Vendor Address: _____

Requested Start Date of Service: _____ ICD10 Diagnosis Code(s): _____

***NUCALA ONLY: For providers in Western PA and West Virginia, the specialty pharmacy will be assigned by Free Market Health**

Buy & Bill Drug Supplied by Specialty Pharmacy (Pharmacy Name: _____ NPI: _____)

<input type="checkbox"/> FASENRA (J0517)	<input type="checkbox"/> NUCALA (J2182)	<input type="checkbox"/> CINQAIR (J2786)	<input type="checkbox"/> TEZSPIRE (J2356)
<input type="checkbox"/> OTHER _____ (J_____)			

For Asthma:

Does the member have **SEVERE** Asthma? YES NO

The member has **UNCONTROLLED** Asthma defined by (answer all that apply):

- ACT Score _____
- ACQ Score _____
- Number of exacerbations has the member had in the past 12 months requiring oral or systemic corticosteroid treatment? _____
- FEV1 (pre-bronchodilator) _____ Date of test: _____

Please list any medications (inhalers, oral medications, injections) the member has been on over the past year for asthma.

- Name: _____ Dose: _____ Duration (months): _____
- Name: _____ Dose: _____ Duration (months): _____
- Name: _____ Dose: _____ Duration (months): _____
- Name: _____ Dose: _____ Duration (months): _____
- Name: _____ Dose: _____ Duration (months): _____

Does the member have asthma with an **eosinophilic phenotype**? YES NO

If YES, please provide: _____

****Please verify member's eligibility and benefits through the health plan****

- Blood eosinophil count _____ cells/microliter
- Date of lab draw: _____

Will the requested product be used as add-on maintenance treatment? YES NO

Will the requested product be used ***in combination with*** Fasenna, Cinqair, Nucala, Tezspire, Xolair or Dupixent?
 YES NO

Has the member tried and failed any of the following? *(circle all that apply)*

- Nucala Xolair Fasenna Cinqair Dupixent Tezspire

Does the member have any contraindications to the following? *(circle all that apply)*

- Nucala Xolair Fasenna Cinqair Dupixent Tezspire

<input type="checkbox"/> New Start	<div style="text-align: right; margin-bottom: 10px;"> <input type="checkbox"/> Continuation of Therapy </div> <p>The use of the requested product has resulted in clinical improvement documented by: <i>(Check all that apply)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Decreased utilization of rescue medications <input type="checkbox"/> Decreased frequency of exacerbations <input type="checkbox"/> Increased predicted FEV1 from pretreatment baseline (Include baseline FEV1_____, Current FEV1_____) <input type="checkbox"/> Reduction in reported asthma-related symptoms <input type="checkbox"/> Decrease in ACQ-6 score by 0.5 or increase in ACT by 3 from pretreatment baseline <p>Will the requested product continue to be used as add-on maintenance therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Will the requested product be prescribed <i>in combination with</i> Fasenna, Nucala, Xolair, Cinqair or Dupixent? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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For Eosinophilic Granulomatosis with Polyangitis (EGPA): Nucala only

Does the member have a history of relapsing disease? YES NO

Is the member on a stable dosage of oral prednisolone or prednisone for at least 4 weeks? YES NO

Will the member be receiving standard of care while on Nucala (glucocorticoid with or without immunosuppressive therapy)? YES NO

<input type="checkbox"/> New Start	<div style="text-align: right; margin-bottom: 10px;"> <input type="checkbox"/> Continuation of Therapy </div> <p>Has treatment with Nucala resulted in an improvement of the member's condition? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
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For Hypereosinophilic Syndrome (HES): Nucala only

Has the member been diagnosed with HES for greater than or equal to 6 months? YES NO

Is there an identifiable non-hematologic secondary cause of HES? YES NO

Does the member have FIP1L1-PDGFR α kinase-positive HES? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Has the member experienced at least 2 HES flares within the past 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO	
What is the member's baseline blood eosinophil count (prior to starting Nucala)? _____ cells/microliter	
Is the member stable on HES therapy (corticosteroids, immunosuppressive or cytotoxic therapy) for at least 4 weeks before starting Nucala? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> New Start	<input type="checkbox"/> Continuation of Therapy
Has treatment with Nucala resulted in decrease in HES flares? <input type="checkbox"/> YES <input type="checkbox"/> NO	

For Chronic Rhinosinusitis with Nasal Polyps (CRSwNP): Nucala only	
Will Nucala be used as add-on maintenance therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Has the member had inadequate results to nasal corticosteroids for at least 8 weeks of use (unless not tolerated or contraindicated)? <input type="checkbox"/> YES <input type="checkbox"/> NO	
The diagnosis is confirmed by the following symptoms (<i>check all that apply</i>)	
<input type="checkbox"/> Nasal drainage <input type="checkbox"/> Nasal blockage/obstruction/congestion <input type="checkbox"/> Facial pressure or pain <input type="checkbox"/> Decrease or loss in sense of smell lasting for at least 12 weeks	
Has the member been diagnosed with bilateral polyps of nasal endoscopy or CT scan? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Provide the member's NPS (bilateral nasal polyp) score: _____	
Provide the member's VAS (visual analog scale) score: _____	
How many surgical procedures has the member had in the past 10 years for removal of nasal polyps? _____	
Will Nucala be used in combination with Fasenra, Cinqair, Tezspire, Xolair or Dupixent? <input type="checkbox"/> YES <input type="checkbox"/> NO	

<input type="checkbox"/> New Start	<input type="checkbox"/> Continuation of Therapy
Has treatment with Nucala resulted in improvement in signs and symptoms documented by an improvement in VAS score? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Will Nucala be prescribed <i>in combination with</i> Fasenra, Nucala, Xolair, Cinqair or Dupixent? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Please attach all pertinent clinical information	
Attached: <input type="checkbox"/> YES <input type="checkbox"/> NO	