Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠
Medication Authorization Request Form
Nucala® (mepolizumab) J2182

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
Date of birth ☐Male ☐Female	**Address**
Diagnosis (include ICD-10)	**City /State/Zip**
Drug Name	**Phone:** ( ) - **Fax:** ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person's Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Is this request for self or office-administration? ☐ Self-administration ☐ Office administration
2. Initial or Continuation request? ☐ Initial ☐ Continuation, please specify the date of last injection_____
3. Is the patient being treated by an allergist, immunologist or pulmonologist? ☐ Yes ☐ No
4. What is the diagnosis for this medication? ☐ Severe asthma with an eosinophilic phenotype
   ☐ Eosinophilic granulomatosis with polyangiitis (EGPA) ☐ Other. Please list indication_____
5. What is the patient's blood eosinophil count in the past 12 months?_____ cells/microliter, Date _____
6. Which of the following has occurred related to severe eosinophilic asthma in the past 12 months? (select all that apply)
   ☐ Repeated hospital/ED visits. Please provide the number of visit(s) per year: _____
   ☐ Regular use of oral corticosteroids. Please list name of medication(s) with doses:_____
   ☐ High dose Inhaled corticosteroids. Please list name of medication(s) with doses:_____
7. What other asthma medications has the patient previously tried? (select all that apply).
   ☐ Inhaled or Oral corticosteroids (ie. Budesonide, Flunisolide, Fluticasone, Prednisone) ☐Inhaled long-acting beta agonist (ie. Serevent®, Foradil®) ☐Combined medications (ie. Advair®, Symbicort®, Dulera®) ☐Leukotriene receptor antagonist (ie. Singulair®) ☐Other, please specify medications used_____
8. Has the patient tried a high dose inhaled corticosteroid in combination with a long acting beta2 agonist or leukotriene receptor antagonist for at least 3 months? ☐ Yes. Please specified staring date of high dose inhaled corticosteroid_____ ☐ No
9. Which medication has the patient tried for at least 3 months in combination with high dose inhaled corticosteroid??
   ☐ Long acting beta 2 agonist such as formoterol or salmeterol ☐ Leukotriene receptor antagonist such as montelukast or zafirlukast
   ☐ None of above medication
10. Has the patient been on chronic systemic corticosteroids? ☐ Yes. Please specify how many days patient was using systemic corticosteroids ☐ No
11. Will the patient be receiving concomitant medication(s) (such as inhaled corticosteroids) while on Nucala®? ☐Yes, please list the name of medication(s) the patient will be using concomitantly with Nucala® _____ ☐ No
12. Will the patient be receiving other biologic medications such as Xolair®, Fasenra® or Cinqair® concurrently with Nucala®? ☐Yes ☐ No
13. Has the patient's asthma improved and become better controlled on Nucala® as demonstrated by the following? (Choose all that apply).
    ☐ Reduction in hospitalizations ☐Reduction in asthma medication use ☐ Reduction in asthma exacerbations ☐ Improvement in pulmonary function tests ☐ Clinically stable ☐ Worsening symptoms
14. Does the patient currently have asthma or have a history of asthma? ☐ Yes ☐ No
15. How was the patient diagnosed with eosinophilic granulomatosis with polyangiitis (EGPA)? (select all that apply) ☐ Histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation ☐ Neuropathy ☐ Pulmonary infiltrates ☐ Allergic rhinitis and nasal polyps ☐ Cardiomyopathy ☐ Glomerulonephritis ☐ Alveolar hemorrhage ☐ Palpable purpura ☐ Antineutrophil cytoplasmic antibody (ANCA) positivity ☐ Other.
16. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

Coverage won't be provided if the prescribing physician's signature and date aren't reflected on this document.

☐ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	Physician's Signature	Date

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	