Today's date: ______________________________ **Date medication needed:** _________________________

Prior Authorization Form – Nucala®

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Check one: ☐ New start ☐ Continued treatment

Patient information (please print)	**Physician information (please print)**	
Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of Birth	Fax #	NPI

☐ **No delivery requested; physician will use office supply. Authorization only.**

☐ **Delivery requested to the physician's office.**

1) Diagnosis for drug requested (must include ICD-10): ______________________________

2) Patient medical information

a. Is the patient 12 years of age or older? ☐ Yes ☐ No

b. 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? If yes, please fax this documentation along with this form. ☐ Yes ☐ No

c. Is the patient currently receiving treatment that does not maintain adequate control of asthma, and Nucala will be used as additional maintenance therapy? ☐ Yes ☐ No

d. Does the patient's current treatment include high-dose inhaled corticosteroids (e.g., Flovent, Pulmicort), with or without oral corticosteroids, in combination with any of the following additional controllers? If yes, check all that apply: ☐ Yes ☐ No

☐ Long-acting beta agonist (e.g., Foradil, Serevent); list drug/dose/duration:

____

☐ Leukotriene inhibitor (e.g., Singulair); list drug/dose/duration:

____

☐ Theophylline; list drug/dose/duration:

____

☐ Other; list drug/dose/duration:

____

☐ The patient is intolerant to or has a contraindication to these agents.

3) Prescription Information

Quantity ______________________________ Refill x ______________ month(s)

Instructions (include dose) ______________________ every ______________________ day(s)/ week(s)/ month(s)

Physician's Signature ____

Please fax this completed form to 215-761-9580.