Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Nucala (Mepolizumab) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Nucala (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)	
NUCALA 100 MG/ML AUTO-INJECTOR	NUCALA 100 MG/ML SYRINGE

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 365 days.
   If the answer to this question is no, go to question 2.

2. Is the patient 6 years of age or older? Y N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of severe asthma in the last 730 days? Y N
   If the answer to this question is yes, go to question 4.
   If the answer to this question is no, go to question 5.

4. Does the patient have a claim for an asthma controller medication in the last 90 days? Y N
   If the answer to this question is yes, go to question 11.
   If the answer to this question is no, denied.

5. Does the patient have a diagnosis of hypereosinophilic syndrome (HES) in the last 730 days? Y N

If the answer to this question is yes, go to question 6.
If the answer to this question is no, go to question 7

6. Is the patient greater than or equal to 12 years of age? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, denied.

7. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) in the last 730 days? Y N
If the answer to this question is yes, go to question 8.
If the answer to this question is no, denied.

8. Is the patient greater than or equal to 18 years of age? Y N
If the answer to this question is yes, go to question 9.
If the answer to this question is no, denied.

9. Has the patient had a trial of oral glucocorticoid therapy in the last 45 days, or is oral glucocorticoid therapy contraindicated? Y N
If the answer to this question is yes, go to question 10.
If the answer to this question is no, denied.

10. Has the patient had a trial of cyclophosphamide, azathioprine, methotrexate or leflunomide in the last 90 days, or is a trial of these medications contraindicated? Y N
If the answer to this question is yes, go to question 11.
If the answer to this question is no, denied.

11. Does the patient have a diagnosis of helminth infection in the last 180 days? Y N
If the answer to this question is yes, go to question 12.
If the answer to this question is no, go to question 13.

12. Does the patient have a claim for an anthelmintic agent in the last 180 days? Y N
If the answer to this question is yes, go to question 13.
If the answer to this question is no, denied.

13. Is the requested quantity greater than 1 syringe per 30 days for patients with asthma OR greater than 3 syringes per 30 days for patients with eosinophilic granulomatosis with polyangiitis (EGPA) or hypereosinophilic syndrome (HES)? Y N
If the answer to this question is yes, denied.
If the answer to this question is no, go to question 14.

14. Is this request for a non-preferred drug? Y N
If the answer to this question is yes, go to question 15.
If the answer to this question is no, approved for 365 days.

15. Has the patient failed a 30 day treatment trial with at least 1 preferred agent within the last 180 days? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 16.

16. Is there a documented allergy or contraindication to preferred agents in this class? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, go to question 17.

17. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
If the answer to this question is yes, approved for 365 days.
If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date