PriorityHealth

Medicare Part B Step Therapy Form

Fax completed form to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Medicare Part B**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Nucala® (mepolizumab)

Member

Last Name: ______________________ First Name: ______________________

ID #: ______________________ DOB: ______________ Gender: ______________

Primary Care Physician: ______________________

Requesting Provider: ______________________ Prov. Phone: ______________ Prov. Fax: ______________

Provider Address: ____

Provider NPI: ______________________ Contact Name: ______________________

Provider Signature: ______________________ Date: ______________

Product and Billing Information

☐ New request ☐ Continuation request - **Original therapy start date**: ______________________

Drug product: ☐ Nucala 100mg powder for injection

Date of last dose (if applicable): ______________________

Date of next dose (if applicable): ______________________

Dose:__________ **Dose Frequency**:______________

Number of doses requested: ______________________

HCPCS Code: ______________________

Place of administration: ☐ Physician's office

☐ Outpatient infusion

Facility: ______________________ NPI:______________________ Fax:______________________

☐ Home infusion

Agency: ______________________ NPI:______________________ Fax:______________________

Billing: ☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:______________________ NPI:______________________ Fax:______________________

ICD-10 Diagnosis code(s): ______________________

All fields must be complete and legible for review. Your office will receive a response via fax.

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Last reviewed 05/2019

Precertification Requirements

NOTE: Step therapy (trial with the below listed drug[s]) is only applicable to members who are enrolled in an MAPD (Medicare Advantage Prescription Drug) plan.

Before this drug is covered, the patient must meet the following:

1. For severe eosinophilic asthma:
   - Must first try 1 high-dose inhaled corticosteroid (ICS)/long-acting B_2-agonist (LABA) inhaler ***in combination*** with 1 other asthma controller drug (e.g. montelukast, Spiriva)

National and Local Coverage Determination Criteria

Priority Health Medicare applies CMS national coverage determination (NCD) and local coverage determination (LCD) criteria for Part B drugs. If no NCD or LCD criteria are available for the state in which the member is receiving the services, the medication must be being used for a medically-accepted diagnosis as defined in the Medicare Benefit Policy Manual Chapter 15 § 50.

Precertification Documentation

A. What condition is this drug being requested for?

☐ Severe eosinophilic asthma
☐ Eosinophilic granulomatosis with polyangiitis

☐ Other: ______________________________

Are you asking for an exception to the above list of diagnoses?

☐ Yes. ***Rationale for exception*:** ______________________________
☐ No

B. For severe eosinophilic asthma, has the patient tried one high-dose inhaled corticosteroid (ICS)/ long-acting B_2-agonist (LABA) inhaler *in combination* with one other asthma controller drug?

☐ Yes. Check all that apply:
- ☐ Advair HFA/Advair Diskus
- ☐ AirDuo Respiclick
- ☐ Breo Ellipta
- ☐ Dulera
- ☐ Montelukast
- ☐ Spiriva Respimat
- ☐ Symbicort

- ☐ Other:______________________________

☐ No

Are you asking for an exception to this requirement?

☐ Yes. ***Rationale for exception***: ______________________________
☐ No

Additional information

Note: Diagnosis of eosinophilic asthma must be confirmed by:

- Sputum eosinophil count of 3% or higher, or
- Asthma-related peripheral blood eosinophil count of at least 150 cells/mcL in the past 6 weeks
- Asthma-related peripheral blood eosinophil count of at least 300 cells/mcL in the past 12 months