Health Partners •••• Medicare

PRIOR AUTHORIZATION REQUEST FORM

Nucala - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

	s) left blank, illegible, or not attached WILL delay the review process.	
Patient Name:	Prescriber Name:	
Member Number:	Fax: Phone:	
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI: State Lic ID:	
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	
REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I the life or health of the enrollee or the enrollee's ability to regain maximum funct	certify that applying the 72 hour standard review timeframe may seriously jeopardize ion.	
Drug Name:		
Strength:		
Directions / SIG:		
Please attach any pertinent medical history including labs and information for this member that may support approval.		
	lowing questions and sign.	
Q1. Is Nucala being prescribed by a pulmonologist, allerg otolaryngologist?	jist, immunologist, rneumatologist, nematologist, or	
☐ Yes	□ No	
Q2. Is the patient 6 years of age or older?		
☐Yes	□ No	
Q3. Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype with absolute blood eosinophil count equal to or greater than 150 microliters (please attach laboratory results)?		
☐ Yes	□No	
Q4. Has the patient tried and had inadequate response, intolerance or contraindication to treatment with an inhaled ICS/LABA (inhaled corticosteroid/long-acting beta-agonist) with or without other controllers, including systemic steroids, antileukotrienes?		
☐ Yes	□ No	
Q5. Does the patient have a diagnosis of relapsing or refi Please attach documentation.	ractory eosinophilic granulomatosis with polyangiitis (EGPA)?	
☐ Yes	□ No	
Q6. Does the patient have a diagnosis of hypereosinophilic syndrome for greater than or equal to 6 months without an identifiable non-hematologic secondary cause?		
Yes	□ No	
I .		

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.	
Patient Name:	Prescriber Name:
Q7. Does the patient have a diagnosis of chronic rhinosi to nasal corticosteroids? Please attach documentation.	nusitis with nasal polyps (CRSwNP) with inadequate response
☐ Yes	□No
Q8. Requested Duration:	
12 Months	
Q9. Additional Information:	
Prescriber Signature	
	2023 Medicare Prior Authorization Request