EXPRESS SCRIPTS®

Clear Print

Prior Authorization Request

NUCALA (mepolizumab)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Fax: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

NUCALA (mepolizumab)		☐ New request	☐ Renewal request*
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Severe Eosinophilic Asthma

INITIAL

- ☐ For the add-on maintenance treatment of severe eosinophilic asthma, AND
- ☐ The patient is 6 years of age or older, AND
- ☐ The patient is inadequately controlled with medium-to-high-dose inhaled corticosteroids (patients 6 to 17 years of age), and 1 or more additional asthma controller(s) (e.g. long-acting beta agonists) *(Please list prior therapies in the chart below)*, OR
- ☐ The patient is inadequately controlled with high-dose inhaled corticosteroids (patients 18 years of age or older), and 1 or more additional asthma controller(s) (e.g. long-acting beta agonists) *(Please list prior therapies in the chart below)*, AND
- ☐ The patient has had 2 or more asthma exacerbations requiring treatment with systemic corticosteroids in the past 12 months and has a blood eosinophil count of 300 cells/µL or greater, OR
- ☐ The patient has a blood eosinophil count of 150 cells/µL or greater at initiation of treatment while receiving maintenance treatment with an oral corticosteroid

RENEWAL

- ☐ The patient has demonstrated a reduction in frequency of clinically significant asthma exacerbations from pre-treatment baseline, OR
- ☐ The patient has demonstrated a reduction in use of rescue medications from pre-treatment baseline

Hypereosinophilic Syndrome

- ☐ For the add-on treatment of hypereosinophilic syndrome (HES) in an adult, AND
- ☐ The patient has a blood eosinophil count of 1000 cells/µL or greater, AND
- ☐ The patient has experienced a history of 2 or more HES flares within the past 12 months, AND
- ☐ The patient's condition is inadequately controlled while on standard therapy (e.g. corticosteroids, immunosuppressive or cytotoxic therapy) *(Please list prior therapies in the chart below)*

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Eosinophilic Granulomatosis with Polyangiitis

INITIAL

- ☐ For the add-on maintenance treatment of eosinophilic granulomatosis with polyangiitis (EGPA) in an adult, AND
- ☐ The patient has a history of relapsing or refractory disease, AND
- ☐ NUCALA will be used in combination with a corticosteroid

RENEWAL

- ☐ The patient has demonstrated no active vasculitis defined as a Birmingham Vasculitis Activity Score (BVAS) of 0, AND
- ☐ The patient is using a daily prednisone or prednisolone dose of 4 mg or less or has tapered off of a corticosteroid

Chronic Rhinosinusitis with Nasal Polyposis

INITIAL

- ☐ For the treatment of severe chronic rhinosinusitis with nasal polyposis (CRSwNP) in an adult, AND
- ☐ The patient has a nasal polyp score (NPS) of 5 or greater, AND
- ☐ The patient has a nasal congestion (NC) score of 2 or greater, AND
- ☐ The patient has been treated with sinus surgery, OR
- ☐ The patient has had an inadequate response or has a documented intolerance to at least 2 nasal corticosteroids, and to an oral corticosteroid *(Please list prior therapies in the chart below)*

RENEWAL

- ☐ The patient has demonstrated clinical improvement from baseline (e.g. a reduction in nasal polyp size, a reduction in nasal congestion, a reduced need for systemic corticosteroids)

OR

- ☐ None of the above criteria applies.

Relevant additional information:

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2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax: Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail: Express Scripts Canada Clinical Services
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5