Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Mepolizumab (Nucala) or Benralizumab (Fasenra) – Medical Necessity Request

****Complete pages 1-4 for New/Initial requests****

Diagnosis

□ **Asthma**

1. What is the prescriber's specialty managing the medication?
   □ Allergy □ Pulmonology □ Other: _____
2. Please indicate the severity of the asthma: □ mild □ moderate □ severe
3. Does the member have asthma with an eosinophilic phenotype? **Yes or No**
   - **If yes:**
     - Is the member currently receiving high dosed inhaled corticosteroid or on oral corticosteroid? **Yes or No**
     - What is the blood eosinophil level while on high dosed inhaled corticosteroid or oral corticosteroid? _____ Date Taken:_____ ***Please submit lab documentation.***
4. Has the member experienced >2 exacerbations requiring oral corticosteroids within the past 12 months? **Yes or No**
5. Has the member had serious asthma exacerbations requiring hospitalization, mechanical ventilation, or visit to the emergency room or urgent care within past 12 months? **Yes or No**
6. Does the member have a baseline Forced Expiratory Volume (FEV1) that is less than 80% of the predicted after bronchodilator use? **Yes or No**
7. Does the member's controlled asthma get worse when the dose of inhaled or systemic corticosteroids are tapered? **Yes or No**
8. Has member received a medium-high dose inhaled corticosteroid? **Yes** or **No**
   - **If yes**: Please provide drug name and strength _____
     Directions_____
     Dates filled within the past several months_____
   - **If No**, Can member try a medium-high dose inhaled corticosteroid instead? **Yes** or **No**
     - **If Yes**: Please notify the pharmacy of the change
     - **If No**:
       - Please provide clinical reason_____
       - Can the member try a low-dose inhaled corticosteroid instead? **Yes or No**
         - **If yes:** Please notify the pharmacy of the change
         - **If No:** Please provide clinical reason why member cannot use any inhaled corticosteroids _____
9. Has member received long-acting beta agonist (LABA) therapy? **Yes or No**
   - **If Yes**, please provide drug name_____
     - Dates filled within the past several months _____
   - **If No,** Can member try LABA therapy instead? **Yes** or **No**
     - **If Yes**: Please notify the pharmacy of the change
     - **If No**, please provide clinical reason_____

Physician office's signature*_____ Print Name_____

***Form must be completed by prescribing physician or his/her representative**

10. Has member received Leukotriene modifier (e.g., montelukast or zafirlukast)? **Yes** or **No**
    - **If Yes**, please provide drug name_____
        - Dates filled within the past several months _____
    - **If No**, Can member try Leukotriene modifier therapy instead? **Yes or No**
        - **If yes**: Please notify the pharmacy of the change
        - **If No,** please provide clinical reason_____

11. Has member received Long-acting muscarinic antagonist (LAMA)? **Yes** or **No**
    - **If Yes**, please provide drug name_____
        - Dates filled within the past several months _____
    - **If No**, Can member try LAMA therapy instead? **Yes** or **No**
        - **If yes**: Please notify the pharmacy of the change
        - **If No,** please provide clinical reason_____

12. Will the member continue to use standard asthma control therapy [e.g., inhaled corticosteroids (ICS), long-acting beta-2-agonist (LABA), leukotriene receptor antagonist (LTRA)] with the requested drug?
    Yes or No
    - **If Yes,** please provide the name(s) of the standard asthma control therapy the member will be receiving:
      _____

13. Will the member be using any other biologic drug [e.g., omalizumab (Xolair), Reslizumab (Cinqair)] with the requested drug? **Yes or No**
    - **If Yes,** please provide drug name and diagnosis it is being used to treat:
      _____

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)**

1. Is the member being managed by an allergist and/or otolaryngologist/ENT (ears, nose, throat) specialist, or a prescriber with expertise in the disease? **Yes or No**

2. Is the member's chronic rhinosinusitis confirmed by nasal endoscopy, anterior rhinoscopy, or computed tomography (CT) scanning? **Yes or No**

3. Does the member have nasal polyps? **Yes or No**

4. Does the member have ongoing symptoms of nasal obstruction? **Yes or No**

5. Will the member be using Mepolizumab (Nucala) as add-on to maintenance treatment (e.g, nasal saline irrigation, intranasal corticosteroids)? **Yes or No**

6. Did the member have an inadequate response to sinonasal surgery? **Yes or No**

7. Is the member a candidate for sinonasal surgery? **Yes or No**

8. Has the member tried an oral corticosteroid?
   - □ **Yes**:
     - Please provide the dates the member tried an oral corticosteroid _____
     - Did the member have an inadequate response to oral corticosteroid therapy? **Yes or No**
     - Was the oral corticosteroid discontinued? **Yes or No**
       - □ **If Yes:** Why was the oral corticosteroid discontinued?_____
   - □ **No**: Can the member try an oral corticosteroid instead?
     - □ **If Yes**: Please notify the pharmacy of the change and return the form.
     - □ **If No**: Please provide the clinical reason why oral corticosteroids cannot be tried:
       _____

9. Has the member tried topical intranasal corticosteroids (INCS)?
   - □ **Yes**:
     - Please provide the dates the member tried topical intranasal corticosteroids (INCS) _____
     - Did the member have an inadequate response to topical intranasal corticosteroid (INCS) **Yes or No**
     - Was the topical intranasal corticosteroids (INCS) discontinued? **Yes or No**
       - □ **If Yes:** Why was the topical intranasal corticosteroids (INCS) discontinued?
         _____
   - □ **No**: Can the member try a topical intranasal corticosteroid (INCS) instead?
     - □ **If Yes**: Please notify the pharmacy of the change and return the form.
     - □ **If No**: Please provide the clinical reason why a topical intranasal corticosteroid (INCS) cannot be tried:
       _____

10. Is the member currently being treated with standard maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids) in combination with Mepolizumab (Nucala)? **Yes or No**

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **If No**: Please let us know the reason why the member cannot try standard nasal polyp maintenance therapy (e.g., nasal saline irrigation, intranasal corticosteroids):

_____

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Eosinophilic Granulomatosis with Polyangiitis (EGPA)**

1. Is the medication managed by an allergist, pulmonologist, rheumatologist, or a prescriber with expertise in the disease? **Yes or No**

2. Does the member currently have or has a history of asthma? **Yes or No**

3. Does the member have Eosinophilia (defined as blood eosinophil level greater than 10% o) or absolute eosinophil count of >1000 cells/mm3? **Yes or No**

4. Please indicate if the member has any of the following (check all that apply):
   - □ Eosinophilic vasculitis, perivascular eosinophilic infiltration or eosinophil-rich granulomatous inflammation.
   - □ Neuropathy
   - □ Pulmonary infiltrates
   - □ Sino-nasal abnormalities
   - □ Cardiomyopathy
   - □ Glomerulonephritis
   - □ Alveolar hemorrhage
   - □ Palpable Purpura
   - □ Anti-neutrophil cytoplasmic anti-body (ANCA) positivity

5. Has the member tried maximally tolerated oral corticosteroid treatment? **Yes or No**
   a. **If Yes**, did the member respond to treatment?
      □ **Yes**: How many weeks of therapy did the member receive:
      _____
      □ **No**: please let us know the specific reason for failure:
      _____
      _____
   b. **If No**, please let us know if the member could try oral corticosteroid treatment instead?
      □ **Yes**: Please notify the pharmacy of the change
      □ **No**: Please provide the clinical reason why oral corticosteroid treatment cannot be tried.
      _____
      _____

6. Will the member be using any other biologic drug with the requested drug? **Yes or No**
   - **If Yes,** please provide drug name and diagnosis it is being used to treat:

   _____

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Hypereosinophilic Syndrome (HES)**

1. Is the member managed by an allergist, immunologist, hematologist, or a prescriber with expertise in the disease? **Yes or No**

2. Has the member had Hypereosinophilic Syndrome (HES) for at least 6 months? **Yes or No**

3. Does the member have an identifiable non-hematological secondary cause of Hypereosinophilic Syndrome (e.g., infection, allergy/atopy, medications, collagen vascular disease, metabolic [e.g., adrenal insufficiency], solid tumor/lymphoma)? **Yes or No**

4. Does the member have a blood eosinophil count of 1000 cells/microL or greater? **Yes or No**

5. Does the member have a history of at least 2 HES flares within the past 12 months (i.e., worsening of clinical symptoms and/or blood eosinophil counts requiring an escalation in therapy)? **Yes or No**

6. Has the member been stable on HES therapy (e.g., oral corticosteroid, immunosuppressant agents, cytotoxic therapy) for at least 4 weeks? **Yes or No**

7. Has the member experienced intolerance or hypersensitivity to HES therapy (e.g., oral corticosteroid, immunosuppressant agents, cytotoxic therapy)? **Yes or No**

8. Does the member have any contraindications to HES therapy? **Yes or No**
    a. If yes, please provide the reason _____

□ **Other diagnosis**: _____

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Mepolizumab (Nucala) or Benralizumab (Fasenra) – Medical Necessity Request

****Complete page 5 only for Subsequent/Renewal requests****

Diagnosis

□ **Asthma**

1. How has the member responded to therapy compared to baseline? (check all that apply):
   - □ Reduction of the number of hospitalizations, need for mechanical ventilation, emergency room visits, or unscheduled visits to healthcare provider due to asthma exacerbations
   - □ Reduction in dose inhaled/oral corticosteroids required to control the patient's asthma
   - □ Reduction in use of rescue medication
   - □ Increase in pulmonary function tests (e.g., Forced Expiratory Volume from baseline)
   - □ Decrease in symptoms and asthma exacerbations
   - □ None of the above
     - **If None of the above**, please provide any additional clinical information pertaining to the request.

     _____

     _____

2. Is the member currently being treated and has been compliant with standard asthma control therapy [e.g., inhaled corticosteroids, long-acting beta-2 agonist (LABA), leukotriene receptor antagonist (LTRA), long-acting muscarinic antagonist (LAMA)] for the past 90 days? **Yes or No**

   If No, please provide specific reason(s):

   _____

3. Will the member continue to use standard asthma control therapy [e.g., inhaled corticosteroids (ICS), long-acting beta-2-agonist (LABA), leukotriene receptor antagonist (LTRA)] with the requested drug?

   Yes or No

   If Yes, please provide the name(s) of the standard asthma control therapy the member will be receiving:

   _____

4. Will the member be using any other biologic drug [e.g., omalizumab (Xolair), Reslizumab (Cinqair)] with the requested drug? **Yes or No**

   i. **If Yes,** please provide drug name and diagnosis it is being used to treat:

   _____

Physician office's signature*_____ Print Name_____

***Form must be completed by prescribing physician or his/her representative**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)**

1. Has the member responded to therapy?

□ Reduction of systemic corticosteroid use
□ Decrease in nasal obstruction, congestion, or other sino-nasal symptoms
□ Improvement in endoscopic nasal polyps score
□ Improvement in loss of smell
□ The member has not required surgery since starting therapy
□ None

- **If None of the above**, please provide any additional clinical information pertaining to the request.

_____

2. Will the member continue standarad maintenance therapy (e.g, nasal saline irrigation, intranasal corticosteroids) in combination with Mepolizumab (Nucala) **Yes or No**

□ **Eosinophilic Granulomatosis with Polyangiitis (EGPA)**

1. How has the member responded to therapy compared to baseline? (check all that apply)

□ Reduction in corticosteroid and/or immunosuppressant doses
□ Reduction in asthma symptoms
□ Reduction in sinus symptoms
□ Reduction in vasculitis
□ Reduced number of hospitalizations or emergency room visits
□ Improvement from baseline in forced expiratory volume in 1 second (FEV1)
□ Improvement in duration of remission or decrease in the rate of relapses
□ None of the above

- **If None of the above**, please provide any additional clinical information pertaining to the request:

_____

2. Will the member be using any other biologic drug with the requested drug? **Yes or No**

- **If Yes,** please provide drug name and diagnosis it is being used to treat:

_____

□ **Hypereosinophilic Syndrome (HES)**

1. How has the member responded to therapy compared to baseline? (check all that apply)

□ Reduction or stabilization in HES therapy (e.g., oral corticosteroid, immunosuppressant agents, cytotoxic therapy) doses
□ Reduction in weariness or tiredness symptoms
□ Reduction in incidence of HES flares (HES flare defined as worsening of clinical signs and symptoms of HES or increasing eosinophils).
□ None of the above

- **If None of the above**, please provide any additional clinical information pertaining to the request:

_____

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

□ **Other diagnosis**: _____

Physician office's signature*_____ Print Name_____
***Form must be completed by prescribing physician or his/her representative**