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 1 and 2 for New/Initial requests****

1. What is the prescriber's specialty? □ Allergy □ Pulmonology □ Rheumatology □ Other: _____

2. Is the medication being administered by a healthcare professional? **Yes or No**

3. Will the member be using Xolair and/or another IL-5 antagonist concomitantly with Mepolizumab (Nucala) or Benrazliumab (Fasenra)? **Yes or No**
   a. If yes, what indication is it being used concomitantly for? _____

4. What is the diagnosis?

□ **Asthma**

a. Is Mepolizumab (Nucala) or Benrazliumab (Fasenra) being used to treat acute asthma symptoms or acute exacerbations? **Yes or No**

b. Please indicate the severity of the asthma: □ mild □ moderate □ severe

c. Does the member have an eosinophilic phenotype? **Yes or No**

d. What was the member's blood eosinophil level? _____ Date Taken:_____

Please submit lab documentation.

e. Has the member tried a high-dose inhaled corticosteroid together with a controller [e.g., long-acting beta-2-agonist (LABA), leukotriene receptor antagonist (LTRA), or theophylline] for at least 3 consecutive months? **Yes or No**

1. If Yes, provide the name(s) of the high-dose inhaled corticosteroid and/or controller, the dose received, and the dates the member received the medication(s).

_____

_____

f. Will the member continue to use baseline therapy (high-dose inhaled corticosteroid with a controller) in conjunction with Mepolizumab (Nucala) or Benrazliumab (Fasenra)? **Yes or No**

1. If Yes, provide the name(s) of the high-dose inhaled corticosteroid and/or controller, the dose received, and the dates the member received the medication(s).

_____

_____

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

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

b. Does the member have Eosinophilia (defined as greater than 10 percent of the white blood cell differential count) or absolute eosinophil count of more than 1000 cells/mm3? **Yes or No**

Continued on p. 2

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: _____

c. Please indicate if the member has any of the following (check all that apply): ***Please send documentation (such as copy of chart or lab data) confirming member's diagnosis.*
□ Eosinophilic vasculitis, perivascular eosinophilic infiltration or eosinophil-rich granulomatous inflammation.
□ Mono- or Polyneuropathy
□ Nonfixed pulmonary infiltrates on X-Rays
□ Abnormality of paranasal sinuses
□ Cardiomyopathy
□ Glomerulonephritis
□ Alveolar hemorrhage
□ Palpable Purpura
□ Anti-neutrophil cytoplasmic anti-body (ANCA) positive

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

□ Other: _____

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 3 only for Subsequent/Renewal requests****

1. What is the prescriber's specialty? □ Allergy □ Pulmonology □ Rheumatology □ Other: _____
2. Is the medication being administered in the physician's office? **Yes or No**
3. Will the member be using Xolair and/or another IL-5 antagonist concomitantly with Mepolizumab (Nucala) or Benrazliumab (Fasenra)? **Yes or No**If yes, what indication is it being used concomitantly for?

Diagnosis

□ Asthma

1. Has the member demonstrated adherence to baseline controller therapy? **Yes or No**

2. Has the member responded to therapy? **Yes or No**
   -If **Yes**, the member responded to therapy by:
   - □ Reduction of asthma exacerbations
   - □ Reduction in daily maintenance oral corticosteroid dose
   - □ Reduction in use of rescue medication
   - □ Improvement in pulmonary functions tests
   - □ Other: _____

3. Will the member continue to use baseline controller therapy (high-dose inhaled corticosteroid with a controller) in conjunction with Mepolizumab (Nucala) or Benrazliumab (Fasenra)? **Yes or No**
   a. If Yes, provide the name(s) of the high-dose inhaled corticosteroid and/or controller, the dose received, and the dates the member received the medication(s).
   _____
   _____

□ Eosinophilic Granulomatosis with Polyangiitis (EGPA)

1. Has the member responded to therapy? **Yes or No**
   -If **Yes**, the member responded to therapy by:
   - □ Reduction in corticosteroid and/or immunosuppressant doses
   - □ Reduction in asthma symptoms
   - □ Reduction in sinus symptoms
   - □ Reduction in vasculitis
   - □ Other: _____

□ Other: _____

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