Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

NAVITUS HEALTH SOLUTIONS

TEXAS MEDICAID

Drug Prior Authorization
Monoclonal Antibodies: mepolizumab (NUCALA)

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:	
1.	Medication Requested (Name): (Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Clinical Criteria (required)

10. Is the member greater than or equal to (≥) six (6) years of age?

- ◯ Yes
  (Go to #11)
- ◯ No (Deny)
  (Go to #11)

11. Does the member have a diagnosis of severe asthma in the last 730 days?

- ◯ Yes
  (Go to #12)
- ◯ No
  (Go to #13)

12. Does the member have a claim for an asthma controller medication in the last 90 days?

Examples of asthma controller medications include: ALVESCO, ARNUITY ELLIPTA, ASMANEX HFA, ASMANEX TWISTHALER, BREO ELLIPTA, budesonide (PULMICORT), DULERA, FLOVENT DISKUS, FLOVENT HFA, fluticasone-salmeterol (ADVAIR DISKUS/ADVAIR HFA, WIXELA), hydrocortisone, methylprednisolone (MEDROL), prednisolone (MILLIPRED), prednisolone, prednisone, QVAR REDIHALER, and SYMBICORT.

- ◯ Yes
  (Go to #21)
- ◯ No (Deny)
  (Go to #13)

13. Is the member greater than or equal to (≥) 12 years of age?

- ◯ Yes
  (Go to #14)
- ◯ No (Deny)
  (Go to #14)

14. Does the member have a diagnosis of hypereosinophilic syndrome (HES) in the last 730 days?

- ◯ Yes
  (Go to #18)
- ◯ No
  (Go to #15)

15. Does the member have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) in the last 730 days?

- ◯ Yes
  (Go to #17)
- ◯ No
  (Go to #16)

16. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) in the last 730 days?

- ◯ Yes
  (Go to #17)
- ◯ No (Deny)
  (Go to #17)

17. Is the member greater than or equal to (≥) 18 years of age?

- ◯ Yes, and the member has a diagnosis of EGPA
  (Go to #18)
- ◯ Yes, and the member has a diagnosis of CRSwNP
  (Go to #20)
- ◯ No (Deny)
  (Go to #18)

18. Has the member had a trial of oral glucocorticoid therapy in the last 45 days, or is oral glucocorticoid therapy contraindicated?

Examples of oral glucocorticoid therapies include: hydrocortisone, methylprednisolone (MEDROL, MILLIPRED), prednisolone, and prednisone.

- ◯ Yes
  (Go to #19)
- ◯ No (Deny)
  (Go to #19)

19. Has the member had a trial of cyclophosphamide, azathioprine, methotrexate (OTREXUP, RASUVO, TREXALL, XATMEP) or leflunomide (ARAVA) in the last 90 days, or is a trial of these medications contraindicated?

- ◯ Yes
  (Go to #21)
- ◯ No (Deny)
  (Go to #20)

20. Will the member have concurrent therapy with intranasal corticosteroids?

Examples of intranasal corticosteroids include: azelastine-fluticasone (DYMISTA), BECONASE, AQ, budesonide, flunisolide, fluticasone propionate (XHANCE), mometasone furoate (NASONEX), OMNARIS, QNASL, and triamcinolone nasal spray.

- ◯ Yes
  (Go to #21)
- ◯ No (Deny)
  (Go to #21)

21. Does the member have a diagnosis of helminth infection in the last 180 days?

- ◯ Yes
  (Go to #22)
- ◯ No
  (Go to #23)

22. Does the member have a claim for an anthelmintic agent in the last 180 days?

Examples of anthelmintic agents include: albendazole (ALBENZA), EMVERM, ivermectin (STROMECTOL), and praziquantel (BILTRICIDE).

- ◯ Yes
(Go to #23)
- ◯ No (Deny)
(Go to #23)

23. Is the requested quantity greater than (>) one (1) syringe per 30 days for members with asthma or chronic rhinosinusitis with nasal polyps (CRSwNP) **OR** greater than (>) three (3) syringes per 30 days for members with eosinophilic granulomatosis with polyangiitis (EGPA) or hypereosinophilic syndrome (HES)?

- ◯ Yes (Deny)
(Go to #24)
- ◯ No (Approve - 365 days)
(Go to #24)

Additional Information

24. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: ____ **Date:** _______________

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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