# TEXAS MEDICAID
# Clinical Edit Prior Authorization
# mepolizumab (NUCALA)

| STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING | |
|---|---|
| Date: | Prescriber First & Last Name: |
| Patient First & Last Name: | Prescriber NPI: |
| Patient Address: | Prescriber Address: |
| Patient ID: | Prescriber Phone: |
| Patient Date of Birth: | Prescriber Fax: |
| **STEP 2: MEDICATION INFORMATION** | |
| Medication Requested (Name): | Quantity Requested: |
| Dose Requested: | Dosing Instructions: |

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

**OR** ☐ CHIP / PERINATE client **(Go to Step 4)**

**STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT**

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

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

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

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

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

## STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

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

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of severe asthma in the last 730 days?

   ☐ Yes (Go to #3) ☐ No (Go to #4)

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

   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 ODT, prednisone, QVAR REDIHALER, or SYMBICORT.

   ☐ Yes (Go to #9) ☐ No (Deny)

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

   ☐ Yes (Go to #7) ☐ No (Go to #5)

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

   ☐ Yes (Go to #6) ☐ No (Deny)

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

   ☐ Yes (Go to #7) ☐ No (Deny)

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

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

   ☐ Yes (Go to #8) ☐ No (Deny)

8. Has the client had a trial of cyclophosphamide, azathioprine, methotrexate or leflunomide in the last 90 days, or is a trial of these medications contraindicated?

   ☐ Yes (Go to #9) ☐ No (Deny)

9. Does the client have a diagnosis of helminth infection in the last 180 days?

☐ Yes (Go to #10) ☐ No (Go to #11)

10. Does the client 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 #11) ☐ No (Deny)

11. Is the requested quantity greater than (>) 1 syringe per 30 days for clients with asthma OR greater than (>) 3 syringes per 30 days for clients with eosinophilic granulomatosis with polyangiitis (EGPA) or hypereosinophilic syndrome (HES)?

☐ Yes (Deny) ☐ No (Approve – 365 days)

**STEP 5: SIGN AND FAX TO:** NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

**Prescriber Signature:** _____ **Date:** _____

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

For questions, please call Navitus Customer Care at 1-877-908-6023.