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**

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

Drug Name: _____ Strength: _____ Directions: _____

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

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

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

13. 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), theophylline] 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: _____

14. 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: _____

□ **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 greater than 10% of the white blood cell differential count) 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.
   - □ Mono- or Polyneuropathy
   - □ Non-fixed (migratory or transitory) pulmonary infiltrates on radiography
   - □ Abnormality of Paranasal sinuses
   - □ Cardiomyopathy
   - □ Glomerulonephritis
   - □ Alveolar hemorrhage
   - □ Palpable Purpura
   - □ Anti-neutrophil cytoplasmic anti-body (ANCA) positive

5. Has the member tried maximally tolerated oral corticosteroid treatment? **Yes or No**
   a. **If Yes**, did the member respond to treatment?
      - □ **Yes**:
      - □ **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 peripheral blood eosinophil count of >1000 cells/microL? **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, or visits to urgent care or emergency room 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), theophylline] 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), theophylline] 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: _____

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

□ **Other diagnosis**: _____

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