Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Nucala - Medicare

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is Nucala being prescribed by a pulmonologist, allergist, immunologist, rheumatologist or hematologist?

☐ Yes ☐ No

Q2. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q3. Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype with absolute blood eosinophil count equal to or greater than 150 microliters?
Please attach laboratory results.

☐ Yes ☐ No

Q4. Has the patient tried and had inadequate response, intolerance or contraindication to treatment with an inhaled corticosteroid/long-acting beta-agonist (ICS/LABA) with or without other controllers, including systemic steroids, antileukotrienes?

☐ Yes ☐ No

Q5. Does the patient have a diagnosis of relapsing or refractory eosinophilic granulomatosis with polyangiitis (EGPA)? Please attach documentation.

☐ Yes ☐ No

Q6. Does the patient have a diagnosis of hypereosinophilic syndrome for greater than or equal to 6 months without an identifiable non-hematologic secondary cause?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q7. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) with inadequate response to nasal corticosteroids?
Please attach documentation.

☐ Yes ☐ No

Q8. Additional Information:

Q9. Requested Duration:

☐ 12 months

Prescriber Signature _____ Date _____

Updated for 2022