Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Nucala - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

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:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

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. Additional Information:

Q8. Requested Duration:

☐ 12 months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request