Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Nucala® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Severe asthma with an eosinophilic phenotype
❑ Eosinophilic granulomatosis with polyangiitis (Churg-Strauss Syndrome)
❑ Hypereosinophilic syndrome
❑ Chronic rhinosinusitis with nasal polyps (CRWsNP)
❑ Other diagnosis: ____ ICD-10 Code(s): ____________________________

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Allergist/Immunologist ❑ Hematologist ❑ Otolaryngologist ❑ Pulmonologist ❑ Rheumatolgist ❑ Other ___________________

For severe asthma with an eosinophilic phenotype, also answer the following:

Has the patient experienced inadequate control of asthmatic symptoms after a minimum of three months use of a high dose corticosteroid and controller medication? ❑ **Yes** ❑ **No**

Has the patient had at least two asthma exacerbations requiring medical intervention within the past 12 months? ❑ **Yes** ❑ **No**

For chronic rhinosinusitis with nasal polyps (CRWsNP), also answer the following:

Has the patient experienced inadequate response to nasal corticosteroid? ❑ **Yes** ❑ **No**

List intranasal corticosteroid tried by the patient and duration of use: ____
____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____
____
____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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