PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For asthma therapy: Nucala (mepolizumab)

Please fax form to: 1-866-840-1509

Please note that the patient **AND** physician must complete this form. **All fields are mandatory and must be completed. Incomplete forms may result in your application being declined.** Please retain a copy of this form for your records.

Instructions:

1. **PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.**
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health (a service provider of your insurance company) by fax to **1-866-840-1509**.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

A. Information to be Completed by Patient

Employee or Insured's Name	Drug Card Number __ __ - __ __ __ __ __ __ - __ __ __ __ __ __ __ __ __ __ - __ __	
Patient's Name	Patient's Date of Birth (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	Relationship to Employee/Insured ❑Employee ❑Spouse ❑Dependent

Please allow two business days for a response once all information is received and complete.
Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.

Please provide contact information and indicate **ONE** method of preferred contact for notification of the results:

❑ E-mail me at:	❑ Call me (and leave a message if I'm not there) at:	❑ Fax me at:
❑ Contact my pharmacy: Pharmacy Name		Pharmacy Phone Number

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN _____

Date: (DD/MMM/YYYY): __ __ / __ __ __ / __ __ __ __

PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For asthma therapy: Nucala (mepolizumab)

Please fax form to: 1-866-840-1509

B. Information to be Completed by Prescribing Physician

Drug Name	Strength	Dose
Nucala (mepolizumab)		

Nucala (mepolizumab) will be eligible for reimbursement only if the patient satisfies the conditions listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. If "None of the above criteria" is indicated, the patient will not be eligible for reimbursement. **For Quebec plan members, please refer to the RAMQ exception drug criteria, if applicable.**

Eligibility Criteria

Please indicate if the patient satisfies the following criteria:

- ❑ **Severe Eosinophilic Asthma (T990000023)**
  - ❑ **Initial Criteria** (approval period of one year):
    The Patient:
    - ❑ Is ≥6 years of age; AND
    - ❑ Has a confirmed diagnosis of severe eosinophilic asthma; AND
    - ❑ Has a blood eosinophil count of ≥ 300 cells/µL (0.3 GI/L) in the past 12 months, and has experienced two or more clinically significant asthma exacerbations, defined as worsening of asthma resulting in administration of systemic corticosteroids for at least 3 days, or an emergency room visit, or hospitalization, in the past 12 months; OR
      - ❑ Has a blood eosinophil count of ≥ 150 cells/µL (0.15 GI/L) and is receiving maintenance treatment with systemic corticosteroids of at least 5.0 mg/day of prednisone or equivalent in the previous 6 months; AND
    - ❑ Has persistent airflow obstruction as indicated by a pre-bronchodilator Forced Expiratory Volume in one second (FEV_1) <80% predicted (in the presence of reduced FEV_1/FVC defined as less than the lower limit of normal); AND
  - ❑ Nucala will be used as an add-on maintenance treatment to high-dose inhaled corticosteroids (patients ≥ 18 years of age) or medium-to-high-dose inhaled corticosteroids (patients 6-17 years of age) and an additional asthma controller(s) (e.g., long-acting beta-agonist); AND
  - ❑ Nucala will not be used as dual therapy with another monoclonal antibody for the treatment of asthma; AND
  - ❑ Physician is a respirologist or is experienced in the management of asthma

  - ❑ **Renewal Criteria** (approval period of one year):
    Treatment with Nucala has resulted in clinical improvement as demonstrated by one or more of the following:
    - ❑ Increase in percent predicted FEV_1 from pretreatment baseline; OR
    - ❑ Decreased use of rescue medications from pretreatment baseline; OR
    - ❑ Decreased frequency of exacerbations requiring an increase in inhaled corticosteroid dose or systemic corticosteroids use from pretreatment baseline

OR

- ❑ **Eosinophilic Granulomatosis with Polyangiitis (82275008)**
  - ❑ **Initial Criteria** (approval period of one year):
    The patient:
    - ❑ Has a confirmed diagnosis of eosinophilic granulomatosis with polyangiitis (also known as Churg-Strauss Syndrome); AND
    - ❑ Is ≥18 years of age; AND

Eligibility Criteria

- ❑ Has had a 3-month trial of a glucocorticoid, unless contraindicated or clinically significant adverse events are experienced; AND
- ❑ Has a history of relapsing or refractory disease; AND
- ❑ Prescribed by or in consultation with a/an pulmonologist, rheumatologist, immunologist, or nephrologist

❑ **Renewal Criteria** (approval period of one year):
Treatment with Nucala has resulted in clinical improvement as demonstrated by:
- ❑ Birmingham Vasculitis Activity Score (BVAS) = 0 (no active vasculitis); AND
- ❑ Prednisolone or prednisone dose less than or equal to 4 mg/day

OR

❑ **Hypereosinophilic Syndrome (393573009)**

❑ **Initial Criteria** (approval period of one year):
The patient:
- ❑ Is ≥18 years of age; AND
- ❑ Has been diagnosed with hypereosinophilic syndrome (HES) for more ≥6 months without an identifiable non-hematologic secondary cause; OR
  - ❑ Has a history of two or more HES flares within the past 12 months; AND
- ❑ Must have blood eosinophil count ≥1000 cells/µL; AND
- ❑ Will use NUCALA as an add-on to a stable dose of HES standard therapy, received for at least 4 weeks prior (HES therapy includes but is not limited to oral corticosteroid, immunosuppressive, and cytotoxic therapy); AND
- ❑ Prescriber is an allergist/immunologist, hematologist, cardiologist or any other specialist in the treatment of HES

❑ **Renewal Criteria** (approval period of one year):
- ❑ Treatment with Nucala has resulted in clinical improvement as demonstrated by a decrease in HES flares from baseline

OR

❑ **Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (41931000119102)**

❑ **Initial Criteria:** (approval period of 6 months)
The patient:
- ❑ Is ≥ 18 years of age; AND
- ❑ Has diagnosis of CRSwNP, meeting the following criteria:
  - ❑ Presence of at least 2 of the following symptoms for 12 weeks:
    - ❑ Nasal blockage/obstruction/congestion; OR
      - ❑ Nasal discharge (anterior/posterior nasal drip); AND
    - ❑ Facial pain/pressure; OR
      - ❑ Reduction or loss of smell; AND
  - ❑ Presence of bilateral nasal polyps diagnosed by:
    - ❑ endoscopy; OR
      - ❑ CT scan; AND
- ❑ Has required at least one prior surgery in the previous 10 years for the removal of nasal polyps; AND
- ❑ Has severe bilateral nasal polyp symptoms with a nasal obstruction symptom visual analogue scale (VAS) score of >5; AND
- ❑ Is eligible for repeat nasal surgery with:
  - ❑ An overall VAS symptom score >7; AND
  - ❑ An endoscopic nasal polyps score (NPS) ≥ 5 with a minimum NPS score of 2 in each nasal cavity; AND
- ❑ Has had an inadequate response to nasal corticosteroids tried at least 8 weeks; OR
  - ❑ Has a contraindication or intolerance to nasal corticosteroids; AND

PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORM
For asthma therapy: Nucala (mepolizumab)

Please fax form to:
1-866-840-1509

Eligibility Criteria

- ❑ Will use Nucala as add-on maintenance treatment with intranasal corticosteroids; AND
- ❑ Is not receiving Nucala in combination with any of the following:
  - Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab)];
  - Anti-IgE therapy [e.g., Xolair (omalizumab)];
  - Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

AND

- ❑ The prescriber is an otolaryngologist, allergist or immunologist or works in consultation with an otolaryngologist, allergist or immunologist

❑ **Renewal Criteria** (approval period of one year):
Treatment with Nucala has resulted in clinical improvement as demonstrated by one of the following:

- ❑ Improved sense of smell; OR
- ❑ Improved VAS symptom score; OR
- ❑ Improved NPS score

OR

❑ None of the above applies

Relevant additional information _____

Physician Information				
Physician's Name	License Number	Telephone Number		Fax Number
Address		City	Province	Postal Code
Physician's Signature			Date: (DD/MMM/YYYY) __ __ / __ __ __ / __ __ __ __	