



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Nucala

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health 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.

Form with fields: Patient Name, Prescriber Name, Member Number, Fax, Phone, Date of Birth, Office Contact, Line of Business, NPI, State Lic ID, Address, City, State ZIP, Primary Phone, Specialty/facility name (if applicable)

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

Form with fields: 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 this a renewal request? If yes, go to 2.

Yes checkbox

No checkbox

Q2. FOR RENEWALS: Has the prescriber provided confirmation of a positive clinical response?

Yes checkbox

No checkbox

Q3. Is Nucala being prescribed by a pulmonologist, allergist, immunologist, rheumatologist, hematologist, or otolaryngologist?

Yes checkbox

No checkbox

Q4. Is the patient 6 years of age or older?

Yes checkbox

No checkbox

Q5. 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)?



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Patient Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q6. Has the patient tried and had inadequate response, intolerance or contraindication to treatment with an inhaled ICS/LABA (inhaled corticosteroid/long-acting beta-agonist) with or without other controllers, including systemic steroids, antileukotrienes?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q7. Does the patient have a diagnosis of relapsing or refractory eosinophilic granulomatosis with polyangiitis (EGPA)? Please attach documentation.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q8. Does the patient have a diagnosis of hypereosinophilic syndrome for greater than or equal to 6 months without an identifiable non-hematologic secondary cause?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q9. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) with inadequate response to nasal corticosteroids? Please attach documentation.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q10. Additional Information:	

Prescriber Signature

Date

v2025