Nucala Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient Information	2. Physician Information
Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
			Specify:
7. Diagnosis			

8. **Approval criteria:** Item (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

☐ Yes ☐ No Does the client have a diagnosis of severe asthma in the last 730 days?
☐ Yes ☐ No Does the client have a diagnosis of hypereosinophilic syndrome (HES) in the last 730 days?
☐ Yes ☐ No Does the client have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) in the last 730 days?
☐ Yes ☐ No Does the client have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) in the last 730 days?
☐ Yes ☐ No Has the client had a trial of oral glucocorticoid therapy in the last 45 days, or is oral glucocorticoid therapy contraindicated?
☐ Yes ☐ No Has the client had a trial of cyclophosphamide, azathioprine, methotrexate, or leflunomide in the last 90 days, or is a trial of these medications contraindicated?
☐ Yes ☐ No Will the client have concurrent therapy with intranasal corticosteroids?
☐ Yes ☐ No Does the client have a diagnosis of helminth infection in the last 180 days?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at https://www.txvendordrug.com/formulary/formulary-search

9. Physician signature

_____ *Prescriber or authorized signature*	_____ *Date*
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
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