Jefferson Health Plans

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	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 the 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 the drug prescribed by or in consultation with appropriate specialist for indication: a pulmonologist, allergist, immunologist, rheumatologist, hematologist, or otolaryngologist?

☐ Yes ☐ No

Q2. Is the patient within the age group listed in the FDA labeling or medically accepted use for the requested adalimumab agent and indication?

☐ Yes ☐ No

Q3. Is this a reauthorization request? If YES, go to 4. If NO, go to 5.

☐ Yes ☐ No

Q4. FOR REAUTHORIZATIONS: Has the prescriber provided confirmation of disease stabilization or positive clinical response?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

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 cells/microliter (please attach laboratory results)? If YES, go to 6. If NO, go to 7.

☐ Yes ☐ 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?

☐ Yes ☐ No

Q7. Does the patient have a diagnosis of relapsing or refractory eosinophilic granulomatosis with polyangiitis (EGPA)? Please attach documentation.

☐ Yes ☐ 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?

☐ Yes ☐ No

Q9. Does the patient have a diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) with inadequate response to nasal corticosteroids? Please attach documentation.

☐ Yes ☐ No

Q10. Has the patient had an inadequate response to nasal corticosteroids?

☐ Yes ☐ No

Q11. Does the patient have a diagnosis of COPD with an eosinophilic phenotype with absolute blood eosinophil count equal to or greater than 300 cells/microliter (please attach laboratory results)?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q12. Has the patient tried and had inadequate response, intolerance or contraindication to treatment with inhaled triple therapy (inhaled ICS (inhaled corticosteroid) AND LABA (long-acting beta-agonist) AND LAMA (long-acting muscarinic antagonist))?

☐ Yes ☐ No

Q13. Is there documentation of an inadequate response, intolerance, or contraindication to ALL formulary agents that are FDA-approved for the requested indication?

☐ Yes ☐ No

Q14. Additional Information:

_____ _____

Prescriber Signature Date

v2026

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