Click here to access the guidelines/NICE algorithm

N&WICS - TA671 - Mepolizumab - Severe eosinophilic asthma		
Before providing patient identifiable data on this form, please confirm that the patient (or in the case of a minor or vulnerable adult with the parent/legal guardian/carer) has given appropriate explicit consent for sensitive personal information on this form to be passed to the CCG and/or CSU for processing this funding request and validating subsequent invoices. Consent given: ☐ If there is more than one NICE-approved treatment available, a discussion between the responsible clinician and the patient has taken place about the advantages and disadvantages of the treatments available. This has taken into consideration therapeutic need and whether or not the patient is likely to adhere to treatment. The most appropriate, least expensive, will be chosen (taking into account administration costs, dosage and price per dose) unless an order of preference is stated in the TAs. ☐		
Patient NHS No:	**Trust:**	**Practice Name:**
Patient Hospital No:	**Consultant Making Request:**	**Practice Postcode:**
Patient's Initials and DoB:		**Practice Code:**
Notification Email Address: (@NHS.net account ONLY)		**Contact name & number:**
Start date of requested treatment:	**Provider:** ☐ Private ☐ NHS **Supplier:** ☐ Homecare ☐ Hospital	**Sub-Type:** N/A **(if applicable)**
By completing this form, you confirm that you intend to use the requested medicinal product described below as agreed in the local commissioning statement. Any requests which fall outside of this use will require an individual funding request (IFR). For support regarding IFRs, please contact: norfolkicd@nhs.net For support regarding the criteria listed below, please contact: norfolknontariff@nhs.net		

Please indicate whether patient meets the following NICE criteria:	Please tick
1. Mepolizumab, as an add-on therapy, is recommended as an option for treating severe refractory eosinophilic asthma, only if: • it is used for adults who have agreed to and followed the optimised standard treatment plan and • the blood eosinophil count has been recorded as 300 cells per microlitre or more and the person has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, or has had continuous oral corticosteroids of at least the equivalent of prednisolone 5 mg per day over the previous 6 months or • the blood eosinophil count has been recorded as 400 cells per microlitre or more and the person has had at least 3 exacerbations needing systemic corticosteroids in the previous 12 months (so they are also eligible for either benralizumab or reslizumab).Mepolizumab is recommended only if the company provides it according to the commercial arrangement.	☐ Yes ☐ No
2. If mepolizumab, benralizumab or reslizumab are equally suitable, start treatment with the least expensive option (taking into account drug and administration costs).	☐ Yes ☐ No
3. At 12 months: • stop mepolizumab if the asthma has not responded adequately or • continue mepolizumab if the asthma has responded adequately and assess response each year.An adequate response is defined as: • a clinically meaningful reduction in the number of severe exacerbations needing systemic corticosteroids or • a clinically significant reduction in continuous oral corticosteroid use while maintaining or improving asthma control.	☐ Yes ☐ No
4. As per NICE guidance, treatment should normally be started with the least expensive drug (considering	

the dose required, price per dose and any additional administration costs). Please confirm that the choice of drug is considered the most cost-effective treatment for this individual patient, noting that alternative treatment options recommended by NICE may be lower in cost, including the use of biosimilar medications if applicable. Where an alternative lower cost treatment is available and has not been tried by the patient, please confirm that the clinical rationale for prescribing has been included in the patients' medical record for the purpose of auditing.	☐ Yes ☐ No
5. The product is being used as described by local commissioning position.	☐ Yes ☐ No

I confirm that the patient meets the criteria for treatment	
Name of person completing:	Contact Details:
Designation of person completing:	Date:

Trust Authorising Pharmacist

Name:

Date: