Prior Authorization Request Form for Monoclonal Antibodies-Anti-IL, Anti-IgE

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Monoclonal Antibodies-Anti-IL, Anti-IgE agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No *Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

- ☐ If not prescribed by one of the following specialist, pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, otolaryngologist, etc., please indicate a specialist consulted:_____
- ☐ If currently using a different Monoclonal Antibodies – Anti-IL, Anti-IgE agent (Fasenra, Nucala, Xolair, Cinqair, Dupixent) than requested, will discontinued the other Monoclonal Antibodies – Anti-IL, Anti-IgE agent OR is not using requested Monoclonal Antibodies – Anti-IL, Anti-IgE agent in combination with Monoclonal Antibodies – Anti-IL, Anti-IgE agent
- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

ASTHMA:

- ☐ Member's asthma severity despite asthma controller medications (please provide asthma severity):_____
- ☐ Member's current therapy maximal therapeutic doses of or intolerance or contraindication to asthma controller medications (please list asthma controller medications):_____
- ☐ Requested medication will be used with standard asthma controller medications (LABA, LAMA, ICS) (Treatment plan):_____
- ☐ For Xolair, member has allergen-induced asthma confirmed by a positive skin test or radioallergosorbent test (RAST) to an unavoidable perennial aeroallergen (e.g. pollen, mold, dust mite, etc.)
- ☐ For Cinqair, member's baseline absolute blood eosinophil count 400 cells/microliter or greater:_____
- ☐ For Nucala or Fasenra, member has asthma with an eosinophilic phenotype with an absolute blood eosinophil count of at least 150 cells/microL:_____

ASTHMA RENEWAL REQUESTS:

- ☐ Documented measurement improvement in severity of asthma evidenced by:_____

- ☐ Member will continue to use standard asthma controller medications (LABA, LAMA, ICS) (Treatment plan):_____

CHRONIC IDIOPATHIC URTICARIA:

- ☐ Documented history of urticarial for at least 3 months
- ☐ Select all that apply:
  - ☐ Requires steroids to control urticarial symptoms: _____
  - ☐ Documented history of therapeutic failure, contraindication or intolerance to ALL of the following: (medication, start date and end date)
    - ☐ H1 Antihistamine: _____
    - ☐ H2 Antihistamine: _____
    - ☐ Leukotriene modifier: _____

CHRONIC IDIOPATHIC URTICARIA RENEWAL REQUESTS:

- ☐ Documented measurement improvement in severity of chronic idiopathic urticarial symptoms evidenced by:_____
- ☐ Prescriber's rationale for continued use:_____

ESOINOPHILIC GRANULOMATOSIS WITH POLYANGITIS (EGPA):

- ☐ Has documented history of asthma
- ☐ Absolute blood eosinophil count 1000 cells/microL or greater OR blood eosinophil level greater than 10% of leukocytes:_____
- ☐ Documented history of at least one of the following:
  - ☐ Histopathological evidence of one of the following:
    - ☐ Eosinophilic vasculitis
    - ☐ Perivascular eosinophilic infiltration
    - ☐ Eosinophil-rich granulomatous inflammation
  - ☐ Neuropathy, mono or poly (monitor deficit or nerve conduction abnormality)
  - ☐ Pulmonary infiltrates, non-fixed
  - ☐ Sino-nasal abnormality
  - ☐ Cardiomyopathy
  - ☐ Glomerulonephritis
  - ☐ Alveolar hemorrhage
  - ☐ Palpable purpura
  - ☐ Positive test for ANCA
- ☐ Has documented history of therapeutic failure of at least 3 months trial of Prednisolone at least 7.5mg/day (or equivalent) unless intolerant or contraindicated:_____

ESOINOPHILIC GRANULOMATOSIS WITH POLYANGITIS (EGPA) RENEWAL REQUESTS:

- ☐ Documented measurable improvement in eosinophilic with polyangilits disease activity evidenced by:_____

HYPEREOSINOPHILIC SYNDROME (HES):

- ☐ Has a diagnosis of hypereosinophilic syndrome
- ☐ Has documented FIP1L1-PDGFRA-negative HES with organ damage or dysfunction
- ☐ Has documented blood eosinophil count ≥1000 cells/microL
- ☐ One of the following:
  - ☐ Requires or has required systemic glucocorticoids to control symptoms
  - ☐ Has documented contraindication or intolerance of systemic glucocorticoids
- ☐ Has documented history of therapeutic failure of at least 3 months trial of Prednisolone at least 7.5mg/day (or equivalent) unless intolerant or contraindicated:_____

HYPEREOSINOPHILIC SYNDROME (HES) RENEWAL REQUESTS:

- ☐ Has documented measurable improvement in disease activity evidenced by:_____
- ☐ Has documented reduction in use of systemic glucocorticoids for this indication

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)