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

FAX this completed form to (877) 386-4695

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

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group 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: _____

Has the member received the appropriate vaccinations as recommended in the FDA-approved package insert, unless contraindicated?	☐ Yes ☐ No *Submit documentation.*
Will the member be evaluated, treated and/or monitored for parasitic (helminth) infection before and/or during treatment?	☐ Yes ☐ No *Submit documentation.*
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, rheumatologist, otolaryngologist, etc., please indicate a specialist consulted:_____
- ☐ The requested medication will NOT be use concurrently with another Monoclonal Antibodies – Anti-IL, Anti-IgE agent (Fasenra, Nucala, Xolair, Cinqair, Dupixent)
- ☐ 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.) AND baseline serum total IgE measurement between 30 and 1,300 International units/mL:_____
- ☐ 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: _____
  - ☐ Dapsone, Sulfasalazine, or Hydroxychloroquine: _____

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:_____

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:

Envolve Pharmacy Solutions 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.)