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

**FAX this completed form to (844) 205-3386**

**OR Mail requests to: 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: _____

**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, Anti-TSLP agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*

☐ Yes

☐ No

Medications Previously Taken (start and end date and dose):_____
_____
_____
_____

- ☐ If not prescribed by one of the following specialist, pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, etc., please indicate a specialist consulted:_____
- ☐ If currently using a different Monoclonal Antibodies – Anti-IL, Anti-IgE, Anti-TSLP agent (Fasenra, Nucala, Xolair, Cinqair, Dupixent, Tezspire), will discontinue the other Monoclonal Antibodies – Anti-IL, Anti-IgE, Anti-TSLP agent prior to starting requested
- ☐ 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):_____
- ☐ 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 has 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 6 weeks
  - ☐ Select all that apply:
    - ☐ Requires steroids to control urticarial symptoms: _____
    - ☐ Documented history of therapeutic failure, contraindication or intolerance to H1 Antihistamine (medication, start date and end date): _____

**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 POLYANGIITIS (EGPA):**

- ☐ For a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA), both of the following:
  - ☐ Documented history of asthma
  - ☐ Documented history of 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
  - ☐ One of the following:
    - ☐ Requires systemic glucocorticoids to maintain remission (medication, start date and end date):_____
    - ☐ Has a contraindication or an intolerance to systemic glucocorticoids:_____
  - ☐ For a member with severe EGPA has a history of therapeutic failure of or contraindication or an intolerance to rituximab or cyclophosphamide:_____

**ESOINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA) RENEWAL REQUESTS:**

- ☐ Documented measurable improvement in eosinophilic with polyangilits disease activity evidenced by:_____
- ☐ Reduction in use of systemic glucocorticoid for EGPA (medication dose):_____

**HYPEREOSINOPHILIC SYNDROME (HES):**

- ☐ For a diagnosis of hypereosinophilic syndrome HES), all of the following:
  - ☐ 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 (medication, start date and end date):_____
    - ☐ Has documented contraindication or intolerance of systemic glucocorticoids:_____

**HYPEREOSINOPHILIC SYNDROME (HES) RENEWAL REQUESTS:**

- ☐ One of the following:
  - ☐ Has documented measurable improvement in disease activity evidenced by:_____
  - ☐ Has documented reduction in use of systemic glucocorticoids for this indication (current dose):_____

**OTHER DIAGNOSES:**

- ☐ Member has a history if therapeutic failure of or contraindication or an intolerance to first line therapies according to consensus treatment guidelines:_____

| 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.)