MONOCLONAL ANTIBODIES (MABs) — ANTI-IL, ANTI-IgE, ANTI-TSLP PRIOR AUTHORIZATION FORM

(form effective 1/8/2024)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative, call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	

CLINICAL INFORMATION

Medication requested:

Preferred Medications:

- ☐ Fasenra Pen
- ☐ Fasenra Syringe
- ☐ Nucala 100 mg/ml Autoinjector
- ☐ Nucala 40 mg/0.4 ml Syringe
- ☐ Tezspire Pen
- ☐ Xolair Syringe
- ☐ Xolair Vial

Non-Preferred Medications:

- ☐ Cinqair Vial
- ☐ Nucala 100 mg/ml Syringe
- ☐ Nucala 100 mg/ml Vial
- ☐ Tezspire Syringe

Strength:

Dosage form (pen, vial, etc):

Dose and directions:	Quantity:	Duration: _____ months
Diagnosis:	Dx code *(required)*:	Weight: _____ lbs/kg
Has the beneficiary used the requested medication in the past 90 days? Submit documentation.		☐ Yes – date of last dose: _____ ☐ No
Is the requested medication being prescribed by or in consultation with a specialist?		☐ Yes ☐ No *Submit documentation of consultation, if applicable.*

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
NPI#:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

INITIAL REQUESTS

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

For a non-preferred drug in this class: Does the beneficiary have a history of trial and failure of or contraindication or an intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition? Refer to **https://papdl.com/preferred-drug-list** for a list of preferred and non-preferred agents in this class.	☐ Yes ☐ No *Submit documentation.*

1. For treatment of ASTHMA:

☐ Has an asthma severity that is consistent with the FDA-approved indication for the requested medication despite use of maximal therapeutic doses of or has contraindication or an intolerance to the following (check all that apply):
- ☐ inhaled glucocorticoid
- ☐ long-acting beta-agonist (LABA)
- ☐ leukotriene modifier
- ☐ other (e.g., tiotropium, theophylline): _____

☐ Will continue to use maximal standard asthma controller medications in addition to the requested medication

☐ **For an anti-IgE MAB (e.g., XOLAIR):**
- ☐ Has moderate-to-severe persistent asthma induced by an unavoidable perennial allergen (pollen, mold, dust mites, etc.)
- ☐ Diagnosis confirmed by positive skin test or radioallergosorbent test (RAST)
- ☐ Has a pretreatment serum total IgE measurement of: _____

☐ **For an anti-IL MAB (e.g., CINQAIR, FASENRA, NUCALA):**
- ☐ Has asthma of an eosinophilic phenotype – Absolute blood eosinophil count: _____/mL Date obtained: _____
- ☐ Has severe asthma

☐ **For an anti-TSLP (e.g., TEZSPIRE):**
- ☐ Has severe asthma

INITIAL REQUESTS (continued)

2. For treatment of CHRONIC SPONTANEOUS (IDIOPATHIC) URTICARIA:
- ☐ Has a history of urticaria for a period of ≥6 weeks
- ☐ Requires use of systemic steroids to control urticarial symptoms
- ☐ Tried and failed the maximally tolerated dose of an H1 antihistamine (e.g., cetirizine/levocetirizine, fexofenadine, loratadine/desloratadine) taken for at least two weeks or has a contraindication or an intolerance to H1 antihistamines

3. For treatment of EGPA:
- ☐ Has a history of asthma
- ☐ Has an absolute blood eosinophil count ≥1000/microliter
- ☐ Has a blood eosinophil level >10% of leukocytes
- ☐ Has evidence of the following *(check all that apply)*:
  - ☐ histopathological evidence of:
    - ☐ eosinophilic vasculitis
    - ☐ perivascular eosinophilic infiltration
    - ☐ eosinophil-rich granulomatous inflammation
  - ☐ neuropathy (nerve deficit or conduction abnormality)
  - ☐ pulmonary infiltrates, non-fixed
  - ☐ sino-nasal abnormality
  - ☐ cardiomyopathy
  - ☐ glomerulonephritis
  - ☐ alveolar hemorrhage
  - ☐ palpable purpura
  - ☐ positive test for ANCA
- ☐ Requires systemic glucocorticoids to maintain remission
- ☐ Has a contraindication or an intolerance to systemic glucocorticoids
- ☐ Has severe EGPA as defined by national treatment guidelines
  - ☐ Tried and failed or has a contraindication or an intolerance to rituximab or cyclophosphamide

4. For treatment of HYPEREOSINOPHILIC SYNDROME (HES):
- ☐ Has documented FIP1L1-PDGFRA-negative HES
- ☐ Has organ damage or dysfunction
- ☐ Has a blood eosinophil count ≥1000/microliter
- ☐ Requires or has required systemic glucocorticoids to maintain remission
  - ☐ Has a contraindication or an intolerance to systemic glucocorticoids

5. For treatment of NASAL POLYPS:
- ☐ Has a history of trial and failure of or contraindication or intolerance to nasal corticosteroids
- ☐ **For an anti-IgE MAB (e.g., XOLAIR):**
  - ☐ Has a pretreatment serum total IgE measurement of: _____

6. For treatment of ALL OTHER DIAGNOSES:
- ☐ List other treatments tried (including start/stop dates, dose, outcomes):

_____

RENEWAL REQUESTS

1. For treatment of ASTHMA:
- ☐ Experienced measurable evidence of improvement in the severity of the asthma condition
- ☐ Will continue to use optimally titrated doses of or has a contraindication or an intolerance to the following (check all that apply):
  - ☐ inhaled glucocorticoid
  - ☐ leukotriene modifier
  - ☐ long-acting beta-agonist (LABA)
  - ☐ other (e.g., tiotropium, theophylline): _____

2. For treatment of CHRONIC SPONTANEOUS (IDIOPATHIC) URTICARIA:
- ☐ Experienced an improvement in symptoms
- ☐ Document rationale for continued use: _____

3. For treatment of EGPA:
- ☐ Experienced measurable evidence of improvement in disease activity
- ☐ Reduction in use of systemic glucocorticoids for the treatment of EGPA

4. For treatment of HYPEREOSINOPHILIC SYNDROME (HES):
- ☐ Experienced measurable improvement in disease activity
- ☐ Reduction in use of systemic glucocorticoids for the treatment of HES

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: