



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

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 #:	
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:
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IV. REQUIRED DOCUMENTATION (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.	<input type="checkbox"/> Yes	Medications Previously Taken (start and end date and dose): _____ _____ _____
	<input type="checkbox"/> No	_____ _____

- 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.pahealthwellness.com/providers/pharmacy.html> under PHW Quantity Limit List), 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: _____

EOSINOPHILIC 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: _____

EOSINOPHILIC 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-PDGFR α -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 :

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