

MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IgE PRIOR AUTHORIZATION FORM (Form effective 1/1/20)

Prior authorization guidelines for **Monoclonal Antibodies, Anti-IL, Anti-IgE** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:		
Contact's phone number:		NPI:	State license #:	
LTC facility contact/phone:		Street address:		
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form (pen, vial, etc):
Dose & directions:	Quantity:	Duration: _____ months
Diagnosis:	Dx code (<i>required</i>):	Weight: _____ lbs / kg
Has the beneficiary used the requested medication in the past 90 days? <i>Submit documentation.</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Will the beneficiary be evaluated, monitored, and treated (if applicable) for helminth infection?		<input type="checkbox"/> Yes <input type="checkbox"/> No

INITIAL requests

For a non-preferred drug in this class: Does the beneficiary have a history of trial and failure of or contraindication or 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.	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
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Complete all sections applicable to the beneficiary and this request. Check all that apply and SUBMIT DOCUMENTATION for each item.

For treatment of asthma:

Is currently receiving optimally titrated doses of, or has a contraindication or intolerance to, the following (*check all that apply*):

inhaled glucocorticoid long-acting beta-agonist (LABA)
 leukotriene modifier other (eg, tiotropium, theophylline): _____

For an anti-IgE MAB (eg 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 serum total IgE measurement between 30 international units (IU)/mL and 1300 IU/mL

For an anti-IL MAB (eg, Cinqair, Fasenra, Nucala):

Has asthma of an eosinophilic phenotype – Absolute blood eosinophil count: _____/ml Date obtained: _____
 Has severe asthma

- For treatment of chronic idiopathic urticaria:**
- Has a history of urticaria for a period of ≥ 3 months
 - Requires use of steroid to control urticarial symptoms
 - Has a history of trial and failure of or contraindication or intolerance to all of the following at maximal tolerated doses (*check all that apply*):
 - H₁ antihistamine
 - H₂ antihistamine
 - leukotriene modifier
 - dapsone, sulfasalazine, or hydroxychloroquine
- For treatment of EGPA:**
- Has a history of asthma and an absolute blood eosinophil count ≥ 1000 /microliter
 - Has a history of asthma and 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
 - Has a history of therapeutic failure of ≥ 3 months of prednisolone ≥ 7.5 mg/day (or equivalent) or has an intolerance or contraindication to systemic corticosteroids
- For Nucala (mepolizumab):**
- For a beneficiary ≥ 50 years of age:**
 - Received the varicella-zoster vaccine (Shingrix/Zostavax) at least 4 weeks prior to initiation of Nucala

RENEWAL requests

Complete all sections applicable to the beneficiary and this request. Check all that apply and SUBMIT DOCUMENTATION for each item.

- 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 intolerance to, the following (*check all that apply*):
 - inhaled glucocorticoid
 - leukotriene modifier
 - long-acting beta-agonist (LABA)
 - other (eg, tiotropium, theophylline): _____
- For treatment of chronic idiopathic urticaria:**
- Experienced an improvement in symptoms
 - Document rationale for continued use: _____
- _____
- _____
- For treatment of EGPA:**
- Experienced measurable evidence of improvement in disease activity

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____

Date: _____

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