HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IgE, ANTI-TSLP

PRIOR AUTHORIZATION FORM (*form effective 1/9/2023*)

Prior authorization guidelines for **Monoclonal Antibodies, Anti-Il, Anti-IgE, Anti-TSLP** 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.

☐New request ☐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:		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 (*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.*

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

INITIAL requests

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:

☐Is currently receiving optimally titrated doses of or has a contraindication or an 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 an anti-TSLP (eg, TEZSPIRE):**
☐ Has severe asthma

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 (eg, cetirizine/levocetirizine, fexofenadine, loratadine/desloratadine) taken for at least 2 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 (eg, XOLAIR):**
☐ Has a serum total IgE measurement between 30 international units (IU)/mL and 1500 IU/mL

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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
     - ☐ long-acting beta-agonist (LABA)
     - ☐ leukotriene modifier
     - ☐ other (eg, 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 TO 866-240-3712

Prescriber Signature:	**Date**: