Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Monoclonal Antibodies (MABs) - Anti-IL, Anti-IgE

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this request for a continuation of therapy with the prescribed Monoclonal Antibody (MAB) – Anti-IL, Anti-IgE? [If yes, skip to question 32.]

☐ Yes ☐ No

Q2. Is the requested MAB – Anti-IL, Anti-IgE, Anti-TSLP being prescribed for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q3. Is the requested MAB – Anti-IL, Anti-IgE, Anti-TSLP age-appropriate according to U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Is the prescribed dose consistent with U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q5. Is the requested MAB – Anti-IL, Anti-IgE, Anti-TSLP being prescribed by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, rheumatologist, etc.)?

☐ Yes ☐ No

Q6. Is the member currently using a different MAB – Anti-IL, Anti-IgE, Anti-TSLP than requested and will discontinue the other MAB prior to starting the requested agent?

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☐ Yes ☐ No

Q7. For a non-preferred MAB – Anti-IL, Anti-IgE, Anti-TSLP does the member have A) A history of therapeutics failure, intolerance or contraindication of the preferred MABs- Anti-IL, Anti-IgE, Anti-TSLP approved or medically accepted for the beneficiary's indication or B) Have a history (within the past 90 days) of being prescribed the same a non-preferred MAB – Anti-IL, Anti-IgE, Anti-TSLP?

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of asthma?

☐ Yes ☐ No

Q9. Does the patient have an asthma severity that is consistent with the U.S. Food and Drug Administration (FDA)approved indication for the prescribed MAB - Anti-IL, Anti-IgE, Anti-TSLP despite maximal therapeutic doses of or intolerance or contraindication to asthma controller medications based on current national treatment guidelines for the diagnosis and management of asthma?

☐ Yes ☐ No

Q10. Will the requested Monoclonal Antibody – Anti-IL, Anti-IgE, Anti-TSLP be used in addition to standard asthma controller medications as recommended by current national treatment guidelines for the diagnosis and management of asthma? [If yes, skip to question 21.]

☐ Yes ☐ No

Q11. Does the patient have a diagnosis of chronic idiopathic urticaria? [If no, skip to question 15.]

☐ Yes ☐ No

Q12. Does the patient have a documented history of urticaria for a period of at least 6 weeks?

☐ Yes ☐ No

Q13. Does the patient require the use of steroids to control urticarial symptoms? [If yes, skip to question 24.]

☐ Yes ☐ No

Q14. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to maximum tolerated doses to an H1 antihistamine (taken for at least 2 weeks)? [If yes, skip to question 24.]

☐ Yes ☐ No

Q15. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)? [If No, skip to Q21].

☐ Yes ☐ No

Q16. Does the patient have a history of asthma?

☐ Yes ☐ No

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Q17. Does the patient have a history of absolute blood eosinophil count greater than or equal to 1000 cells per microliter or blood eosinophil level greater than 10 percent of leukocytes?

☐ Yes ☐ No

Q18. Does the patient have a history of at least one of the following: A) Histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophilic-rich granulomatous inflammation, B) Neuropathy, mono or poly (motor deficit or nerve conduction abnormality), C) Pulmonary infiltrates, non-fixed, D) Sino-nasal abnormality, E) Cardiomyopathy, F) Glomerulonephritis, G) Alveolar hemorrhage, H) Palpable purpura, or I) Positive test for ANCA?

☐ Yes ☐ No

Q19. Has the patient required systemic glucocorticoids to maintain remission OR has a contraindication or an intolerance to systemic glucocorticoids? [if Yes skip to question 24]

☐ Yes ☐ No

Q20. For severe EPGA, as defined by national treatment guidelines, does the patient have a history of therapeutic failure of or a contraindication or an intolerance to rituximab or cyclophosphamide? [if Yes skip to question 24]

☐ Yes ☐ No

Q21. Does the patient have a diagnosis of hypereosinophilic syndrome (HES)? [If No skip to Q23]

☐ Yes ☐ No

Q22. Does the patient have A) Documented FIP1L1-PDGFRA-negative HES with organ damage or dysfunction; B) Blood eosinophil count ≥1000 cells/microL AND C) Requires or has required systemic glucocorticoids to maintain remission or has a contraindication or intolerance to systemic glucocorticoids? [if Yes skip to question 24]

☐ Yes ☐ No

Q23. For all other diagnosis, does the patient have a history of therapeutic failure, contraindication or intolerance to first line therapy(ies) if applicable according to consensus guidelines?

☐ Yes ☐ No

Q24. Is the request for Xolair (omalizumab)? [if NO, skip to Q26]

☐ Yes ☐ No

Q25. Does the patient have a diagnosis of allergen-induced asthma (allergic asthma confirmed by either a positive skin test or radioallergosorbent test [RAST]) to an unavoidable perennial aeroallergen (e.g., pollen, mold, dust mite, etc.)?

☐ Yes ☐ No

Q26. Is the request for Cinqair (reslizumab) for a diagnosis of asthma with an eosinophilic phenotype? [If no, skip to 28]

☐ Yes ☐ No

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Q27. Does the patient have an absolute blood eosinophil count greater than or equal to 400 cells per microliter?

☐ Yes ☐ No

Q28. Is the request for Nucala (mepolizumab) for a diagnosis of asthma? [if no, skip to Q30]

☐ Yes ☐ No

Q29. Does the patient have asthma with an eosinophilic phenotype with an absolute blood eosinophil count greater than or equal to 150 cells per microliter?

☐ Yes ☐ No

Q30. Is the request for Fasenra (benralizumab)?

☐ Yes ☐ No

Q31. Does the patient have asthma with an eosinophilic phenotype with absolute blood eosinophil count ≥ 150 cells/microliter?

☐ Yes ☐ No

Q32. Is the requested Monoclonal Antibody – Anti-IL, Anti-IgE, Anti-TSLP being prescribed by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, rheumatologist, etc.)?

☐ Yes ☐ No

Q33. Will the patient use the requested agent in combination with another monoclonal antibody (MAB) – Anti-IL, Anti-IgE, Anti-TSLP?

☐ Yes ☐ No

Q34. Does the patient have a diagnosis of asthma with A) Measurable evidence of improvement in the severity of the asthma condition and B) Continues to use the requested MAB in addition to standard asthma controller medications as recommended by current national treatment guidelines for the diagnosis and management of asthma? [If No, skip to Q35]

☐ Yes ☐ No

Q35. Does the patient have a diagnosis of chronic idiopathic urticaria with A) Improvement of symptoms and B) Documented rationale of continued use? [If No. skip to Q36]

☐ Yes ☐ No

Q36. Does the patient have a diagnosis of HES or EGPA with A) Measurable evidence of improvement in disease activity and B) Reduction in use of systemic glucocorticoids?

☐ Yes ☐ No

Q37. Does the prescription for a MAB – Anti-IL, Anti-IgE, Anti-TSLP exceed the quantity limit?

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☐ Yes	☐ No
Q38. Additional Information:	

Prescriber Signature _____ Date _____

Updated for 2023