United Healthcare Community Plan

Asthma and COPD Agents: Monoclonal Antibodies
– Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to **866-940-7328**. If you have questions, please call **800-310-6826**. **This form may contain multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.**

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____ **Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____**		

Section B - Provider Information				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information	
Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Is this member pregnant? □ Yes □ No **If yes, what is this member's due date?**	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No

2. Will this be used in combination with any other monoclonal antibodies?
   ☐ Yes. Specify the monoclonal antibodies the requested product will be used with: _____
   ☐ No

3. Provide patient's current body weight (kg): _____kg Date taken: _____

4. Indicate patient's diagnosis and answer the associated questions as indicated:
   ☐ Moderate to severe asthma (questions 5-11)
   ☐ Severe asthma with eosinophilic phenotype (questions 12-19)
   ☐ Chronic rhinosinusitis with nasal polyposis (questions 20-26)
   ☐ Chronic spontaneous urticaria (questions 27-31)
   ☐ COPD with eosinophilic phenotype (questions 32-36)
   ☐ Eosinophilic granulomatosis with polyangiitis (questions 37-42)
   ☐ Hypereosinophilic syndrome (questions 43-50)
   ☐ IgE-mediated food allergy (questions 51-54)

For diagnosis of moderate to severe asthma

5. Was this prescribed by, or in consultation with a provider who specializes in the treatment of asthma?
   ☐ Yes ☐ No

6. Provide the following for patient:
   - Pre-treatment serum IgE level: _____IU/mL Date taken: _____
   - Percent predicted FEV1: _____% Date taken: _____
   - Asthma phenotype. Check all that apply:
     ☐ Allergic
     ☐ Eosinophilic
     ☐ Other, specify: _____

7. Does patient have documentation of functional impairment due to poor asthma control or exacerbations (e.g. limitation of activities of daily living, nighttime awakenings) ☐ Yes ☐ No
   If yes, how many times per week? _____/week

8. How many times does patient use a SABA (e.g. albuterol, levalbuterol) for symptom control? _____/day

9. Is patient currently being treated with any of the following medications? Check all that apply:
   - ☐ Long-acting beta-2 agonist (LABA)
   - ☐ Long-acting muscarinic agonist (LAMA)
   - ☐ Leukotriene receptor antagonist
   - ☐ Maximally tolerated ICS/LABA combination product
   - ☐ Medium to high-dose, or maximally tolerated inhaled corticosteroid (ICS)
   - ☐ Other, specify: _____

10. Will patient continue to use asthma controller medication(s) in combination with the requested medication, unless contraindicated? ☐ Yes ☐ No

11. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduced asthma exacerbations, FEV1, reduced hospitalizations)? ☐ Yes ☐ No

For diagnosis of severe asthma with eosinophilic phenotype

12. Was this prescribed by, or in consultation with a provider who specializes in the treatment of severe asthma with eosinophilic phenotype?
    ☐ Yes ☐ No

13. Does patient have documentation of functional impairment due to poor asthma control or exacerbations (e.g. limitation of activities of daily living, nighttime awakenings) ☐ Yes ☐ No
    If yes, how many times per week? _____/week

14. How many times does patient use a SABA (e.g. albuterol, levalbuterol) for symptom control? _____/day

15. Provide the following for patient:
    - Percent predicted FEV1: _____% Date taken: _____
    - Absolute blood eosinophil count: _____cells/ µL Date taken: _____

16. Is patient currently being treated with any of the following medications? Check all that apply:
    - ☐ Long-acting beta-2 agonist (LABA)
    - ☐ Long-acting muscarinic agonist (LAMA)
    - ☐ Leukotriene receptor antagonist
    - ☐ High-dose, or maximally tolerated inhaled corticosteroid (ICS)
    - ☐ Other, specify: _____

17. Will patient continue to use asthma controller medication(s) in combination with the requested medication, unless contraindicated? ☐ Yes ☐ No

18. For depemokimab-ulaa (Exdensur) and m**epolizumab (Nucala)** requests, has patient had treatment with any of the following that has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 12 weeks]? Check all that apply:
    - ☐ Benralizumab
    - ☐ Dupilumab
    - ☐ Mepolizumab
    - ☐ Reslizumab

19. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduced asthma exacerbations, FEV1, reduced hospitalizations)? ☐ Yes ☐ No

For diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)

20. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of CRSwNP?
    ☐ Yes ☐ No

21. Does patient have a diagnosis of bilateral sinonasal polyposis confirmed by an endoscopy or computed tomography (CT)? ☐ Yes ☐ No

22. Does patient have any of the following symptoms? Check all that apply:
    - ☐ Nasal congestion, blockage, or obstruction with moderate to severe symptom severity
    - ☐ Nasal discharge
    - ☐ Facial pain or pressure
    - ☐ Reduction or loss of smell

23. Does patient have a history of failure, contraindication or intolerance to any of the following? Check all that apply:
    - ☐ Oral systemic corticosteroid therapy for 10 to 14 days within the last 24 months
    - ☐ Intranasal corticosteroid (minimum trial of two months)

24. Will patient continue to use a intranasal corticosteroid with the use of a monoclonal antibody unless contraindicated? ☐ Yes ☐ No

25. For mepolizumab (Nucala) requests, has patient had treatment with any of the following that has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 16 weeks]? Check all that apply:
    - ☐ Dupilumab
    - ☐ Omalizumab
    - ☐ Tezepelumab-ekko

26. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in nasal congestion/obstruction severity, reduction in nasal polyps)?
    ☐ Yes ☐ No

For diagnosis of chronic spontaneous urticaria (CSU)

27. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of CSU?
    ☐ Yes ☐ No

28. Has patient experienced urticaria for ≥ 8 consecutive weeks? ☐ Yes ☐ No

29. Provide patient's Urticaria Activity Score (UAS7):_____ Date taken: _____

30. Has patient tried and failed TWO second generation H-1 antihistamines up to maximally tolerated dose or after titration up to 2-4 times FDA approved dose for a minimum of two weeks each, unless all are contraindicated? ☐ Yes ☐ No

31. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in UAS7 score)? ☐ Yes ☐ No

For diagnosis of COPD with eosinophilic phenotype

32. Was this prescribed by, or in consultation with, a provider who specializes in COPD with eosinophilic phenotype?
☐ Yes ☐ No

33. Provide the following for patient:
    - Absolute blood eosinophil count: _____cells/ µL Date taken: _____
    - Percent predicted FEV1: _____% Date taken: _____
    - Number of exacerbations in the last 12 months:
        - Moderate exacerbations: _____
        - Severe exacerbations: _____

34. Is patient currently being treated with any of the following? Check all that apply:
☐ Maximal inhaled therapy (ICS + LABA + LAMA)
☐ Double maintenance therapy (LABA + LAMA) if ICS is contraindicated

35. Has patient had treatment with dupilumab that has been ineffective, contraindicated, or not tolerated [minimum trial of 12 weeks]?
☐ Yes ☐ No

36. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g. improvement in FEV1, dyspnea score, reduced COPD exacerbations)?
☐ Yes ☐ No

For diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)

37. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of EGPA?
☐ Yes ☐ No

38. Does patient have any of the following characteristics typical of EGPA? Check all that apply:
☐ Biopsy showing white blood cells present outside blood vessels (extravascular eosinophils)
☐ Cardiomyopathy
☐ Pulmonary infiltrates
☐ Paranasal sinus abnormality
☐ Mononeuropathy (including multiplex) or polyneuropathy
☐ Glomerulonephritis
☐ Alveolar hemorrhage

☐ Palpable purpura
☐ Anti-neutrophil cytoplasmic antibody (ANCA) positive

39. Does patient have history of asthma and eosinophilia (150 cells/ µL or > 10% of leukocytes)?
☐ Yes ☐ No

40. Does patient have history of relapsing or refractory disease treated with background prednisolone/prednisone without or without immunosuppressive therapy?
☐ Yes ☐ No

41. For mepolizumab (Nucala) requests has patient had treatment with benralizumab that has been ineffective, contraindicated, or not tolerated [minimum trial of 1 year]?
☐ Yes ☐ No

42. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduction in relapses, severity or frequency of EGPA-related symptoms)?
☐ Yes ☐ No

For diagnosis of hypereosinophilic syndrome (HES)

43. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of HES?
☐ Yes ☐ No

44. Has patient experienced HES for ≥ 6 months? ☐ Yes ☐ No

45. Does patient have a history of ≥ 2 flares in the past 12 months? ☐ Yes ☐ No

46. Does patient have FIP1L1-PDGFRα-negative disease? ☐ Yes ☐ No

47. Does patient have an identifiable non-hematologic secondary cause of HES (e.g., drug hypersensitivity, parasitic helminth infection, HIV, non-hematologic malignancy)? ☐ Yes ☐ No

48. Provide the following for patient:
    - Absolute blood eosinophil count: _____cells/ µL Date taken: _____

49. For mepolizumab (Nucala) requests has patient had treatment with benralizumab that has been ineffective, contraindicated, or not tolerated [minimum trial of 1 year]?
☐ Yes ☐ No

50. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., decrease in HES flares)? ☐ Yes ☐ No

For diagnosis of IgE-mediated food allergy

51. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of IgE-mediated food allergies? ☐ Yes ☐ No

52. Has patient's diagnosis of IgE-mediated food allergy been confirmed by any of the following? Check all that apply:
    - ☐ Food specific skin prick test
    - ☐ IgE antibody testing
    - ☐ Oral food challenge

53. Has patient been prescribed or has access to epinephrine for emergencies? ☐ Yes ☐ No

54. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber Specialty	Date