UnitedHealthcare Community Plan

Monoclonal Antibodies – Anti-IL, Anti-IgE - Pennsylvania
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.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

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: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Asthma □ Chronic idiopathic urticaria □ Eosinophilic granulomatosis with polyangiitis (EGPA) □ Hypereosinophilic syndrome (HES)
□ **Yes** □ **No**	**Is the requested medication prescribed by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.)?**
□ **Yes** □ **No**	**Is the patient currently using a different monoclonal antibody (MAB) - anti-interleukin (IL), anti-immunoglobulin E (IgE) than requested?**
□ **Yes** □ **No** □ **Not applicable**	**If yes to the above question, will the patient discontinue the other MAB - Anti-IL, Anti-IgE prior to starting the requested agent?**
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure, intolerance, or contraindication of the preferred MAB - Anti-IL, Anti-IgE approved or medically accepted for the patient's indication?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ **Yes** □ **No**	**Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred MAB - Anti-IL, Anti-IgE?**
ASTHMA	
□ **Yes** □ **No**	**Does the patient have an asthma severity that is consistent with the FDA-approved indication for the prescribed medication 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**	**Will the patient use the requested medication in addition to standard asthma controller medications as recommended by current national treatment guidelines for the diagnosis and management of asthma?**
□ **Yes** □ **No**	**For Xolair (omalizumab), does the patient have a diagnosis of allergen-induced asthma (allergic asthma) to an unavoidable perennial aeroallergen (e.g., pollen, mold, dust mite, etc.) confirmed by any of the following?** *(If yes, check which applies)* □ Positive skin test □ Radioallergosorbent test
□ **Yes** □ **No**	**For Cinqair (reslizumab), does any of the following apply?** *(If yes, check which applies)* □ Diagnosis of asthma with an eosinophilic phenotype □ Patient has an absolute blood eosinophil count greater than or equal to 400 cells/microliter
□ **Yes** □ **No**	**For Nucala (mepolizumab), does any of the following apply?** *(If yes, check which applies)* □ Diagnosis of asthma with an eosinophilic phenotype □ Patient has an absolute blood eosinophil count greater than or equal to 150 cells/microliter
□ **Yes** □ **No**	**For Fasenra (benralizumab), does any of the following apply?** *(If yes, check which applies)* □ Diagnosis of asthma with an eosinophilic phenotype □ Patient has an absolute blood eosinophil count greater than or equal to 150 cells/microliter
CHRONIC IDIOPATHIC URTICARIA	
□ **Yes** □ **No**	**Does the patient have a documented history of urticaria for a period of at least 3 months?**
□ **Yes** □ **No**	**Does the patient require steroids to control urticarial symptoms?**
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to maximum tolerated doses of any of the following?** *(If yes, check which applies)* □ Histamine 1 (H1) antihistamine □ Histamine 2 (H2) antihistamine □ Leukotriene modifier

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EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)	
□ **Yes** □ **No**	**Is the diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA) supported by any of the following?** *(If yes, check which applies)* □ A documented history of asthma □ A documented history of absolute blood eosinophil count greater than or equal to 1000 cells/microliter or blood eosinophil level > 10% of leukocytes
□ **Yes** □ **No**	**Does the patient have a documented history of any of the following?** *(If yes, check which applies)* □ Histopathological evidence of ONE of the following: Eosinophilic vasculitis, Perivascular eosinophilic infiltration, or Eosinophil-rich granulomatous inflammation □ Neuropathy, mono or poly (motor deficit or nerve conduction abnormality) □ Pulmonary infiltrates, non-fixed □ Sino-nasal abnormality □ Cardiomyopathy □ Glomerulonephritis □ Alveolar hemorrhage □ Palpable purpura □ Positive test for antineutrophil cytoplasmic antibodies (ANCA)
□ **Yes** □ **No**	**Does the patient have a documented history of therapeutic failure (or intolerance or contraindication) of greater than or equal to 3 months of prednisolone greater than or equal to 7.5 mg/day (or equivalent)?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
HYPEREOSINOPHILIC SYNDROME (HES)	
□ **Yes** □ **No**	**Does the patient have documented FIP1L1-PDGFRA-negative hypereosinophilic syndrome (HES) with organ damage or dysfunction?**
□ **Yes** □ **No**	**Does the patient have a documented blood eosinophil count greater than or equal to 1000 cells/microliter?**
□ **Yes** □ **No**	**Does the patient require or has required systemic glucocorticoids to control symptoms?**
□ **Yes** □ **No**	**Does the patient have a documented contraindication or intolerance of systemic glucocorticoids?**
CONTINUATION OF THERAPY – ASTHMA	
□ **Yes** □ **No**	**Is the patient using the requested medication in combination with another MAB - Anti-IL, Anti-IgE?**
□ **Yes** □ **No**	**Is there documented measurable evidence of improvement in the severity of the asthma condition?**
□ **Yes** □ **No**	**Does the patient continue to use the requested medication in addition to standard asthma controller medications as recommended by current national treatment guidelines for the diagnosis and management of asthma?**
CONTINUATION OF THERAPY - CHRONIC IDIOPATHIC URTICARIA	
□ **Yes** □ **No**	**Is the patient using the requested medication in combination with another MAB - Anti-IL, Anti-IgE?**
□ **Yes** □ **No**	**Is there documentation of any of the following?** *(If yes, check which applies)* □ Improvement of symptoms □ Rationale for continued use
CONTINUATION OF THERAPY - EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)	
□ **Yes** □ **No**	**Is the patient using the requested medication in combination with another MAB - Anti-IL, Anti-IgE?**
□ **Yes** □ **No**	**Is there documented measurable evidence of improvement in disease activity?**
CONTINUATION OF THERAPY - HYPEREOSINOPHILIC SYNDROME (HES)	
□ **Yes** □ **No**	**Is the patient using the requested medication in combination with another MAB - Anti-IL, Anti-IgE?**
□ **Yes** □ **No**	**Is there documentation of any of the following?** *(If yes, check which applies)* □ Measurable evidence of improvement in disease activity □ Reduction in use of systemic glucocorticoids for this indication

Provider Signature: _____ **Date:** _____