# *IL-5 Antagonists Drugs*
# *Prior Authorization of Benefits Form*

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**
**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 1-800-454-3730.**

| **1. Patient information** | **2. Physician information** |
|---|---|
| Patient name: _____ | Prescribing physician: _____ |
| Patient ID #: _____ | Physician address: _____ |
| Patient DOB: _____ | Physician phone #:_____ |
| Date of Rx: _____ | Physician fax #: _____ |
| Patient phone #: _____ | Physician specialty: _____ |
| Patient email address: _____ | Physician DEA: _____ |
| | Physician NPI #: _____ |
| | Physician email address: _____ |

| **3. Medication** | **4. Strength** | **5. Directions** | **6. Quantity per 30 days** |
|---|---|---|---|
| _____ | _____ | _____ | Specify: _____ |
| **7. Diagnosis:** _____ | | | |

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment will be considered under the following conditions:

1) Patient meets the FDA approved age for submitted diagnosis; and
2) Is dosed within FDA approved dosing for submitted diagnosis and age; and
3) Patient has a diagnosis of severe asthma with an eosinophilic phenotype; and
    a) Patient has a pretreatment blood eosinophil count of ≥ 150 cells per mcL within the previous six weeks or blood eosinophils of ≥ 300 cells per mcL within 12 months prior to initiation of therapy; and

b) Symptoms are inadequately controlled with documentation of current treatment with a high-dose inhaled corticosteroid (ICS) given in combination with a controller medication (long-acting beta2-agonist [LABA] and leukotriene receptor antagonist [LTRA]) for a minimum of three consecutive months, with or without oral corticosteroids. Patient must be compliant with therapy, based on pharmacy claims; and
c) Patient has a history of two or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA; and
d) A pretreatment forced expiratory volume in one second (FEV1) < 80% predicted in adults and < 90% in adolescents; or

4) Patient has a diagnosis of eosinophilic granulomatosis with polyangiitis; and
a) Patient has documentation of an adequate trial and therapy failure with systemic glucocorticoids; and
b) One of the following:
i. Eosinophil count greater than 1000 cells/mcL; or
ii. Eosinophil count greater than 10% of the total leukocyte count; and

5) Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist.

If the criteria for coverage are met, an initial authorization will be given for three months to assess the need for continued therapy. Requests for continuation of therapy will be based on continued medical necessity and will be considered when the following criteria are met:

Severe asthma with an eosinophilic phenotype:
1) Patient continues to receive therapy with an ICS, LABA and LTRA; and
2) Patient has experienced a reduction in asthma signs and symptoms including wheezing, chest tightness, coughing, shortness of breath; or
3) Patient has experienced a decrease in administration of rescue medication (albuterol); or
4) Patient has experienced a decrease in exacerbation frequency; or
5) Patient has experienced an increase in predicted FEV1 from the pretreatment baseline.

Eosinophilic Granulomatosis with Polyangiitis:
1) Patient has demonstrated a positive clinical response to therapy (increase in remission time).

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

**Non-preferred**

☐ Fasenra ☐ Nucala Auto-Injector ☐Nucala Prefilled Syringe

**Is prescriber and allergist, immunologist, pulmonologist, or rheumatologist?**

☐ **Yes, document specialty:**

_____

☐ **No** If no, note consultation with specialist:
Consultation date:_____ Physician name, specialty and phone: _____

**Will the patient be taking requested medication in combination with another monoclonal antibody?**

☐ No ☐ Yes

☐ **Severe asthma with an eosinophilic phenotype:**

**Pretreatment blood eosinophil count (attach lab)**: _____ Date obtained: _____

OR

**Blood eosinophil count obtained within 12 months prior to initiation of treatment (attach lab):**

_____
Date obtained: _____

**Pretreatment baseline ppFEV$_1$:** _____Date obtained: _____

**Document current use of:**
**High-dose inhaled corticosteroid:** Drug name: _____ Strength: _____
Dosing instructions: _____ Trial start date: _____

**Long-Acting Beta2-Agonist:** Drug name: _____ Strength: _____
Dosing instructions: _____ Trial start date: _____

**Leukotriene receptor antagonist:** Drug name: _____ Strength: _____
Dosing Instructions: _____ Trial start date: _____

**Does patient have a history of two or more exacerbations in the previous year despite regular use of high-dose ICS plus a LABA and LTRA?** ☐ No ☐ Yes (provide dates): _____

☐ **Eosinophilic Granulomatosis with Polyangiitis:**

**Document trial of systemic glucocorticoid:** Drug name: _____ Strength: _____
Dosing instructions: _____ Trial start and end date:_____

**Pretreatment blood eosinophil count (attach lab)**: Date obtained:
**Eosinophil count greater than 10% of the total leukocyte count (attach lab):**_____
Date Obtained:_____

**For renewals only:**
**Severe asthma with an eosinophilic phenotype:**

**Does patient continue to receive therapy with an ICS, LABA and LTRA?** ☐ No ☐ Yes

**Please indicate if the patient has experienced any of the following (check all that apply):**

☐ Reduction in asthma signs and symptoms including:

- Wheezing
- Chest tightness
- Coughing
- Shortness of breath

☐ Decrease in administration of rescue medications (albuterol)

☐ Decrease in exacerbation frequency

☐ Increase in ppFEV$_1$ from the pretreatment baseline Current ppFEV$_1$:_____
Date obtained: _____

Please describe:

_____

_____

**Eosinophilic granulomatosis with polyangiitis:**
**Has patient demonstrated a positive clinical response to therapy (increase in remission time)?**

☐ No

☐ Yes, please describe:

_____

_____

Medical or contraindication reason to override trial requirements:

_____

_____

**Attach lab results and other documentation as necessary.**

**9. Physician signature**

_____ _____
Prescriber or authorized signature Date

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.*
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.