**HEALTH PARTNERS PLANS**
***PRIOR AUTHORIZATION REQUEST FORM***

# MAB's - Anti-IL, Anti-IgE, Anti-TLSP

**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.**

| | | |
|---|---|---|
| Member Name: | Prescriber Name: | |
| HPP Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Member 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. The request is for renewal of a prior authorization for the MABs - Anti-IL, Anti-IgE, Anti-TSLP that was previously approved. If YES, go to 18.

☐ Yes ☐ No

Q2. The member meets ALL of the following:

☐ Is prescribed the requested drug 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

☐ Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Is prescribed by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, hematologist/oncologist, rheumatologist, etc.)

☐ If currently using a different MAB - Anti-IL, Anti-IgE, Anti-TSLP than requested, will discontinue the other MAB - Anti-IL, Anti-IgE, Anti-TSLP prior to starting the requested agent

Q3. For a non-preferred MAB - Anti-IL, Anti-IgE, Anti-TSLP, BOTH of the following: If YES, go to 5.

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☐ Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred MABs - Anti-IL, Anti-IgE, Anti-TSLP approved or medically accepted for the beneficiary's indication

☐ For a non-preferred MAB - Anti-IL, Anti-IgE, Anti-TSLP with a corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the Preferred Drug List (PDL), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug

Q4. Has a current history (within the past 90 days) of being prescribed the same non-preferred MAB - Anti-IL, Anti-IgE, Anti-TSLP (does not apply to non-preferred MABs - Anti-IL, Anti-IgE, Anti-TSLP when a corresponding biosimilar/brand biologic/unbranded biologic is preferred) See the PDL for the list of preferred MABs - Anti-IL, Anti-IgE, Anti-TSLP at: https://papdl.com/preferred-drug-list

☐ Yes ☐ No

Q5. For a diagnosis of ASTHMA, BOTH of the following:

If YES, go to 14.

☐ Has an asthma severity that is consistent with the FDA-approved indication for the prescribed MAB - Anti-IL, Anti-IgE, Anti-TSLP despite maximal therapeutic doses of or contraindication or intolerance to standard asthma controller drugs based on current national treatment guidelines for the diagnosis and management of asthma

☐ Will use the requested MAB - Anti-IL, Anti-IgE, Anti-TSLP in addition to standard asthma controller drugs as recommended by current national treatment guidelines for the diagnosis and management of asthma

Q6. For a diagnosis of CHRONIC SPONTANEOUS URTICARIA, has a history of urticaria for a period of at least six weeks.

☐ Yes ☐ No

Q7. The member meets ONE of the following:

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☐ Requires systemic steroids to control urticarial symptoms

☐ Has a history of therapeutic failure of or a contraindication or an intolerance to maximum tolerated doses of an H1 antihistamine taken for at least two weeks

Q8. For a diagnosis of EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA), has a diagnosis of EGPA supported by BOTH of the following:

If NA, go to 12.

☐ A history of asthma

☐ A history of absolute blood eosinophil count 1000 cells/microL or blood eosinophil level >10% of leukocytes

Q9. A history of at least ONE of the following:

☐ Histopathological evidence of ONE of the following:Eosinophilic vasculitis, perivascular eosinophilic infiltration, 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 ANCA

Q10. ONE of the following:

☐ Requires systemic glucocorticoids to maintain remission

☐ Has a contraindication or an intolerance to systemic glucocorticoids

Q11. For a beneficiary with severe EGPA as defined by national treatment guidelines, has a history of therapeutic failure of or a contraindication or an intolerance to rituximab or cyclophosphamide.

☐ Yes ☐ No

Q12. For a diagnosis of HYPEREOSINOPHILIC SYNDROME (HES), all of the following:

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☐ Has FIP1L1-PDGFRA-negative HES with organ damage or dysfunction
☐ Has a blood eosinophil count 1000 cells/microL
☐ Requires or has required systemic glucocorticoids to maintain remission OR has a contraindication or an intolerance to systemic glucocorticoids

Q13. For all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines

☐ Yes ☐ No

Q14. For Xolair (omalizumab) for a diagnosis of asthma, has a diagnosis of allergen-induced asthma (allergic asthma confirmed by either a positive skin test or radioallergosorbent test) to an unavoidable perennial aeroallergen (e.g., pollen, mold, dust mite, etc.).

☐ Yes ☐ No

Q15. For Cinqair (reslizumab) for a diagnosis of asthma with an eosinophilic phenotype, has an absolute blood eosinophil count 400 cells/microL.

☐ Yes ☐ No

Q16. For Nucala (mepolizumab) for a diagnosis of asthma, has asthma with an eosinophilic phenotype with absolute blood eosinophil count 150 cells/microL.

☐ Yes ☐ No

Q17. For Fasenra (benralizumab), has asthma with an eosinophilic phenotype with absolute blood eosinophil count 150 cells/microL.

☐ Yes ☐ No

Q18. The member meets ALL of the following:

☐ Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
☐ Is prescribed a MAB - Anti-IL, Anti-IgE, Anti-TSLP by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, rheumatologist, etc.)
☐ Is not using the requested MAB - Anti-IL, Anti-IgE, Anti-TSLP in combination with another MAB - Anti-IL, Anti-IgE, Anti-TSLP

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Q19. For a diagnosis of asthma, BOTH of the following:

☐ Has measurable evidence of improvement in the severity of the asthma condition

☐ Continues to use the requested MAB - Anti-IL, Anti-IgE, Anti-TSLP in addition to standard asthma controller drugs as recommended by current national treatment guidelines for the diagnosis and management of asthma

Q20. For a diagnosis of chronic spontaneous urticaria, BOTH of the following:

☐ Experienced improvement of symptoms

☐ Has a documented rationale for continued use

Q21. For a diagnosis of HES or EGPA, has ONE of the following:

☐ Measurable evidence of improvement in disease activity

☐ Reduction in use of systemic glucocorticoids for this indication

Q22. For a non-preferred MAB - Anti-IL, Anti-IgE, Anti-TSLP with a corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug. See the PDL for the list of preferred MABs - Anti-IL, Anti-IgE, Anti-TSLP at: https://papdl.com/preferred-drug-list.

☐ Yes ☐ No

Q23. Additional Information:

_____ _____

Prescriber Signature Date

*v2026*