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 – Anti-IL, Anti-IgE?
[If yes, skip to question 39.]

☐ Yes ☐ No

Q2. Is the requested Monoclonal Antibody – Anti-IL, Anti-IgE 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 Monoclonal Antibody – Anti-IL, Anti-IgE 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 Monoclonal Antibody – Anti-IL, Anti-IgE being prescribed by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, rheumatologist, etc.)?

☐ Yes ☐ No

Q6. Has the patient received appropriate vaccinations as recommended in the U.S. Food and Drug Administration (FDA)-approved package labeling unless contraindicated?

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☐ Yes ☐ No

Q7. Will the patient be evaluated, treated, and/or monitored for parasitic (helminth) infection before and/or during treatment with the requested Monoclonal Antibody - Anti-IL, Anti-IgE as recommended in FDA-approved package labeling?

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of asthma?
[If no, skip to question 11.]

☐ 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 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 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 3 months?

☐ Yes ☐ No

Q13. Does the patient require the use of steroids to control urticarial symptoms?
[If yes, skip to question 34.]

☐ Yes ☐ No

Q14. Does the patient have a documented history of therapeutic failure, contraindication, or intolerance to maximum tolerated doses of all of the following:
A) H1 antihistamine,
B) H2 antihistamine,
C) Leukotriene modifier,
D) Dapsone, sulfasalazine, or hydroxychloroquine?
[If yes, skip to question 34.]

☐ Yes ☐ No

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Q15. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)?

☐ Yes ☐ No

Q16. Does the patient have a documented history of asthma?

☐ Yes ☐ No

Q17. Does the patient have a documented 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 documented 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 had a documented history of therapeutic failure of greater than or equal to 3 months of prednisolone greater than or equal to 7.5 mg per day (or equivalent)?
[If yes, skip to question 38.]

☐ Yes ☐ No

Q20. Has the patient had a documented history of intolerance or contraindication to therapy with prednisolone greater than or equal to 7.5 mg per day (or equivalent)?
[If yes, skip to question 38.]

☐ Yes ☐ No

Q21. 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.)?
[If no, skip to question 25.]

☐ Yes ☐ No

Q22. Does the patient have a total IgE measurement between 30 International Units per milliliter and 1300 International Units per milliliter?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q23. Is this request for the Xolair vial product formulation?
[If yes, skip to question 50.]

☐ Yes ☐ No

Q24. Is this request for the non-preferred Xolair syringe product formulation?
[If yes, skip to question 32.]

☐ Yes ☐ No

Q25. Does the patient have asthma with an eosinophilic phenotype?

☐ Yes ☐ No

Q26. Is this request for Fasenra?
[If no, skip to question 28.]

☐ Yes ☐ No

Q27. Does the patient have an absolute blood eosinophil count greater than or equal to 150 cells per microliter?
[If yes, skip to question 50.]

☐ Yes ☐ No

Q28. Is this request for Cinqair for a diagnosis of asthma with an eosinophilic phenotype?
[If no, skip to question 30.]

☐ Yes ☐ No

Q29. Does the patient have an absolute blood eosinophil count greater than or equal to 400 cells per microliter?
[If yes, skip to question 32.]

☐ Yes ☐ No

Q30. Is this request for Nucala for a diagnosis of asthma?

☐ Yes ☐ No

Q31. Does the patient have asthma with an eosinophilic phenotype with an absolute blood eosinophil count greater than or equal to 150 cells per microliter?
[If yes, skip to question 50.]

☐ Yes ☐ No

Q32. Has the patient had a documented history of therapeutic failure, intolerance, or contraindication of the preferred Monoclonal Antibody - Anti-IL, Anti-IgE approved or medically accepted for the indication?
[If yes, skip to question 50.]

☐ Yes ☐ No

Q33. Does the patient have a current history (within the past 90 days) of being prescribed the same requested non-

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Patient Name:	Prescriber Name:

preferred Monoclonal Antibody – Anti-IL, Anti-IgE?
[If yes, skip to question 50.]

☐ Yes ☐ No

Q34. Is this request for the Xolair vial product formulation?
[If yes, skip to question 50.]

☐ Yes ☐ No

Q35. Is this request for the non-preferred Xolair syringe product formulation?

☐ Yes ☐ No

Q36. Has the patient had a documented history of therapeutic failure, intolerance, or contraindication of the preferred Monoclonal Antibody - Anti-IL, Anti-IgE approved or medically accepted for the indication?
[If yes, skip to question 50.]

☐ Yes ☐ No

Q37. Does the patient have a current history (within the past 90 days) of being prescribed the same requested non-preferred Monoclonal Antibody – Anti-IL, Anti-IgE?
[If yes, skip to question 50.]

☐ Yes ☐ No

Q38. Is this request for Nucala?
[If yes, skip to question 50.]

☐ Yes ☐ No

Q39. 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

Q40. Is the requested Monoclonal Antibody – Anti-IL, Anti-IgE being prescribed by or in consultation with an appropriate specialist (i.e., pulmonologist, allergist, immunologist, dermatologist, rheumatologist, etc.)?

☐ Yes ☐ No

Q41. Is the patient being monitored and treated, if applicable, for parasitic (helminth) infection as recommended in the Food and Drug Administration (FDA)-approved package labeling?

☐ Yes ☐ No

Q42. Will the patient use the requested agent in combination with another monoclonal antibody (MAB) – Anti-IL, Anti-IgE?

☐ Yes ☐ No

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Q43. Does the patient have a diagnosis of asthma?
[If no, skip to question 46.]

☐ Yes ☐ No

Q44. Has the patient had a documented measurable evidence of improvement in the severity of the asthma condition?

☐ Yes ☐ No

Q45. Will the patient continue to use the requested Monoclonal Antibody – Anti-IL, Anti-IgE in addition to standard asthma controller medications as recommended by current national treatment guidelines for the diagnosis and management of asthma?

☐ Yes ☐ No

Q46. Does the patient have a diagnosis of chronic idiopathic urticaria?
[If no, skip to question 48.]

☐ Yes ☐ No

Q47. Was there an improvement of symptoms and a rationale for continued use?

☐ Yes ☐ No

Q48. Does the patient have a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)?

☐ Yes ☐ No

Q49. Was there a documented measurable evidence of improvement in disease activity?

☐ Yes ☐ No

Q50. Will the patient use the requested agent in combination with another monoclonal antibody (MAB) – Anti-IL, Anti-IgE?

☐ Yes ☐ No

Q51. Additional Information:

Prescriber Signature _____ Date _____

Updated for 2022

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