UnitedHealthcare Community Plan

Antiasthmatic Monoclonal Antibodies, IL-5 Antagonists - 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.

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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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- What is the patient's diagnosis? (check which applies)

□ Severe asthma with an eosinophilic phenotype □ Eosinophilic granulomatosis with polyangiitis (EGPA)

□ Other, **List diagnosis**: _____

- Is there documentation of blood eosinophil count (in the absence of other potential causes of eosinophilia) of any of the following: □ Yes □ No (check all that apply)

□ Greater than or equal to (≥) 150 cells/μL in prior 6 weeks
List blood eosinophil count/date: _____

□ Greater than or equal to (≥) 300 cells/μL in prior 12 months
List blood eosinophil count/date: _____

□ White blood cells present outside blood vessels (extravascular eosinophils)

□ Migratory spots or lesions on a chest X-ray (pulmonary infiltrates)

□ Sinus problems (acute or chronic sinusitis)

□ Damage to one or more nerve groups (mononeuropathy or polyneuropathy)

- Is the requested medication being prescribed by, or in consultation with one of the following specialist: □ Yes □ No (check which applies)

□ Allergy □ Pulmonology □ Immunology □ Cardiology □ Hematology □ Rheumatology

- Has the patient demonstrated failure or intolerance to a majority of the preferred Antiasthmatic Monoclonal Antibodies – IL-5 Antagonists? □ Yes □ No □ N/A (No preferred formulary alternatives available)

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

If no, list reason: _____

_____

Requests for BENRALIZUMAB (FASENRA)/RESLIZUMAB (CINQAIR) & Diagnoses of SEVERE ASTHMA WITH EOSINOPHILIC PHENOTYPE:

- Does the patient have a diagnosis of severe asthma with an eosinophilic phenotype? □ Yes □ No
If no, list diagnosis: _____

- Does the patient have uncontrolled or inadequately controlled severe asthma defined by at least one of the following? □ Yes □ No (check which applies)

□ FEV_1 less than (<) 80% predicted

□ Two or more bursts of systemic corticosteroids in the previous 12 months

□ Poor symptom control (e.g., ACQ score consistently greater than 1.5 or ACT score consistently less than 20)

□ None of the above

- Does the patient have history of failure (remains symptomatic after 6 weeks), contraindication or intolerance to high-dose inhaled corticosteroid in combination with additional controller(s)? □ Yes □ No

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Is the requested medication being used in combination with additional asthma controller medications? □ Yes □ No
If yes, list medications: _____

- Is the requested medication being used in combination with other monoclonal antibodies for the treatment of asthma? (e.g. mepolizumab, reslizumab, benralizumab, omalizumab) □ Yes □ No
If yes, list medications: _____

Requests for EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA):

- Does the patient have history of failure, contraindication or intolerance to one of the following: □ Yes □ No (check which applies)

□ Oral corticosteroids □ Inhaled corticosteroids

□ Immunosuppressants (e.g. cyclophosphamide, azathioprine, methotrexate)

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Member First name:	Member Last name:	Member DOB:

- Is the requested dose of the medication less than or equal to (≤) 300mg every 4 weeks? □ Yes □ No
If yes, List dose and frequency: _____

- Has the patient demonstrated failure or intolerance to a majority of the preferred Antiasthmatic Monoclonal Antibodies – IL-5 Antagonists? □ Yes □ No □ N/A (No preferred formulary alternatives available)
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
If no, list reason: _____

_____

Requests for CONTINUATION OF THERAPY:

- Is there clinical documentation of disease stability or improvement compared to baseline measures? □ Yes □ No

Provider Signature: _____ **Date:** _____