United Healthcare Community Plan

Asthma and COPD Agents: Monoclonal Antibodies - Anti-IgE Antibodies

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.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

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

United Healthcare Community Plan

Asthma and COPD Agents: Monoclonal Antibodies - Anti-IgE Antibodies

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No

   If yes, Is there clinical documentation of disease stability or improvement compared to baseline measures?
   ☐ Yes ☐ No

2. Indicate patient's diagnosis:

   ☐ Chronic rhinosinusitis with nasal polyposis
   ☐ Moderate to severe persistent allergic asthma
   ☐ Chronic spontaneous urticaria
   ☐ Other, specify: _____

3. Was this prescribed by, or in consultation with, a specialist in allergy, dermatology, pulmonology, immunology, or ENT (ear, nose, throat)?
   ☐ Yes ☐ No

4. Will this be used in combination with any other monoclonal antibodies? (e.g., benralizumab, dupilumab, mepolizumab, reslizumab, etc.)
   ☐ Yes ☐ No

5. Provide the following for patient (not applicable for diagnosis of chronic spontaneous urticaria):

   Pre-treatment serum IgE level: _____IU/mL Date taken: _____
   Current body weight (kg) _____kg Date taken: _____

Moderate to severe persistent allergic asthma

6. Has patient had reactivity to a perennial aeroallergen? ☐ Yes ☐ No

7. What is the patient's FEV1% predicted? _____ Date taken: _____

8. Does patient have documentation of functional impairment due to poor asthma control or exacerbations (e.g. limitation of activities of daily living, nighttime awakenings) ☐ Yes ☐ No
   If yes, how many times per week? _____/week

9. How many times does patient use a SABA (e.g. albuterol, levalbuterol) for symptom control? _____/day

10. Has patient remained uncontrolled with either of the following medications (used separately or simultaneously) within the last year? Check all that apply:
    ☐ Inhaled corticosteroid (ICS)
    ☐ Long-acting beta agonist (LABA)
    ☐ Long-acting muscarinic agonist (LAMA)
    ☐ Leukotriene receptor antagonist
    ☐ Other, specify: _____

Chronic spontaneous urticaria (CSU)

11. Has provider confirmed that the underlying cause of patient's condition is NOT considered to be any other allergic condition(s) or other forms of urticaria? ☐ Yes ☐ No

12. Has the patient been evaluated for triggers and is being managed to avoid triggers (e.g., NSAIDS, psychological stress, dietary habits)? ☐ Yes ☐ No

13. Has patient had baseline assessment using any of the following assessment tools? Check all that apply:
    - ☐ Urticaria activity score (UAS7)
    - ☐ Angioedema activity score (AAS)
    - ☐ Dermatology Life QualityIndex (DLQI)
    - ☐ Angioedema Quality of Life (AE-QoL)
    - ☐ Chronic Urticaria Quality of Life Questionnaire (CU-Q2oL)

14. Has patient had an inadequate response to any of the following therapies? Check all that apply:
    - ☐ Second-generation H1 antihistamine (two-week minimum trial)
    - ☐ Increase in dose of second-generation H1 antihistamine at maximum tolerated dose
    - ☐ Second-generation H1-antihistamine with a leukotriene antagonist
    - ☐ Second-generation H1-antihistamine with another H1-antihistamine
    - ☐ Second-generation H1-antihistamine with a H2-antihistamine
    - ☐ Other, specify: _____

Chronic rhinosinusitis with nasal polyposis (CRSwNP)

15. Has patient had diagnosis of bilateral sinonasal polyposis confirmed by an endoscopy, rhinoscopy or computed tomography (CT)? ☐ Yes ☐ No

16. Has patient had at least two of the following symptoms? Check all the apply:
    - ☐ Nasal blockage, obstruction, or congestion
    - ☐ Purulent nasal discharge
    - ☐ Facial pain or pressure
    - ☐ Reduction or loss of smell

17. Does patient have current persistent symptomatic nasal polyps despite maximal treatment (within the last year) with any of the following? Check all that apply:
    - ☐ Oral systemic corticosteroid
    - ☐ Intranasal corticosteroid

18. Will patient continue use of an intranasal corticosteroid with the use of omalizumab (Xolair)? ☐ Yes ☐ No

CHART NOTES, LABS AND TEST RESULTS ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date