



Request for Prior Authorization
IL-5 ANTAGONISTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Prescriber must complete all information above, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for IL-5 antagonists. Requests will not be considered with concurrent use with another monoclonal antibody. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:

- 1) Is requested for an FDA approved or compendia indicated diagnosis; and
2) Patient meets the FDA approved or compendia indicated age and dose for submitted diagnosis; 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/mcL within the previous 6 weeks or blood eosinophils of >=300 cells/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 3 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 (2) 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 1 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 > 1000 cells/mcL; or
ii. Eosinophil count > 10% of the total leukocyte count; or
5) Patient has a diagnosis of hypereosinophilic syndrome (HES); and
a) Patient has been diagnosed with HES for >= 6 months prior to starting treatment; and
b) Documentation that non-hematologic secondary causes of HES have been ruled out; and
c) Documentation patient does not have FIP1L1-PDGFRa kinase-positive HES; and
d) Documentation of >= 2 HES flares within the previous 12 months while on stable HES therapy (e.g., chronic or episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy); and
e) Patient has a blood eosinophil count >= 1,000 cells/mcL; and
f) Medication will be used in combination with stable doses of at least one other HES therapy; and
6) Prescribed by or in consultation with an allergist, hematologist, immunologist, pulmonologist, or rheumatologist.

If the criteria for coverage are met, an initial authorization will be given for 3 months for a diagnosis of severe asthma with an eosinophilic phenotype and eosinophilic granulomatosis with polyangiitis or 6 months for a diagnosis of hypereosinophilic syndrome 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



Request for Prior Authorization
IL-5 ANTAGONISTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

- 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).

Hypereosinophilic Syndrome:

- 1) Patient has demonstrated a positive clinical response to therapy (improvement of symptoms and/or reduction in the number of flares); and
2) Medication continues to be used in combination with stable doses of at least one other HES therapy.

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

Preferred

Non-Preferred

- Boxes for Fasenra Auto-Injector, Nucala Auto-Injector, and Nucala Prefilled Syringe.

Table with 4 columns: Strength, Dosage Instructions, Quantity, Days Supply

Diagnosis: \_\_\_\_\_

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

Yes, document specialty: \_\_\_\_\_

No If no, note consultation with specialist:

Consultation Date: \_\_\_\_\_ Physician Name, Specialty & 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 ppFEV1: \_\_\_\_\_ 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: \_\_\_\_\_



Request for Prior Authorization
IL-5 ANTAGONISTS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Does patient have a history of two (2) 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 & end date:

Pretreatment blood eosinophil count (attach lab): Date Obtained:

OR

Eosinophil count > 10% of the total leukocyte count (attach lab): Date Obtained:

[ ] Hypereosinophilic Syndrome:

Has patient been diagnosed with HES for >= 6 months prior to starting treatment?

[ ] No [ ] Yes Date of diagnosis:

Have non-hematologic secondary causes of HES been ruled out? [ ] No [ ] Yes

Does patient have FIP1L1-PDGFRa kinase-positive HES? [ ] No [ ] Yes

Has patient had >= 2 HES flares within the previous 12 months while on stable HES therapy?

[ ] No

[ ] Yes Provide dates of HES flares:

HES therapy & dates of therapy:

Does patient have a blood eosinophil count >= 1,000 cells/mcL? [ ] No [ ] Yes Date obtained:

Will medication be used in combination with stable doses of at least one other HES therapy?

[ ] No

[ ] Yes Drug Name & Dosing Instructions:

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:

- o wheezing
o chest tightness
o coughing
o shortness of breath

[ ] Decrease in administration of rescue medications (albuterol)

[ ] Decrease in exacerbation frequency

[ ] Increase in ppFEV1 from the pretreatment baseline Current ppFEV1: Date Obtained:

Please describe:



Request for Prior Authorization  
IL-5 ANTAGONISTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

**Eosinophilic Granulomatosis with Polyangiitis:**

**Has patient demonstrated a positive clinical response to therapy (increase in remission time)?**

- No
- Yes, please describe: \_\_\_\_\_

**Hypereosinophilic Syndrome:**

**Has patient demonstrated a positive clinical response to therapy (improvement in symptoms and/or reduction in the number of flares)?**

- No
- Yes, please describe: \_\_\_\_\_

**Is medication being used in combination with stable doses of at least one other HES therapy?**

- No     Yes    Drug Name: \_\_\_\_\_    Dosing Instructions: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

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

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.