Asthma and COPD Agents: Monoclonal Antibodies

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

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

2. Will this be used in combination with any other monoclonal antibodies?
   - ☐ Yes. Specify the monoclonal antibodies the requested product will be used with: _____
   - ☐ No

3. Provide patient's current body weight (kg): _____kg Date taken: _____

4. Indicate patient's diagnosis and answer the associated questions as indicated:
   - ☐ Moderate to severe asthma (questions 5-11)
   - ☐ Severe asthma with eosinophilic phenotype (questions 12-19)
   - ☐ Chronic rhinosinusitis with nasal polyposis (questions 20-26)
   - ☐ Chronic spontaneous urticaria (questions 27-31)
   - ☐ COPD with eosinophilic phenotype (questions 32-36)
   - ☐ Eosinophilic granulomatosis with polyangiitis (questions 37-42)
   - ☐ Hypereosinophilic syndrome (questions 43-50)
   - ☐ IgE-mediated food allergy (questions 51-54)

For diagnosis of moderate to severe asthma

5. Was this prescribed by, or in consultation with a provider who specializes in the treatment of asthma?
   ☐ Yes ☐ No

6. Provide the following for patient:
   - Pre-treatment serum IgE level: _____IU/mL Date taken: _____
   - Percent predicted FEV1: _____% Date taken: _____
   - Asthma phenotype. Check all that apply:
     - ☐ Allergic
     - ☐ Eosinophilic
     - ☐ Other, specify: _____

7. 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

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

9. Is patient currently being treated with any of the following medications? Check all that apply:
   - ☐ Long-acting beta-2 agonist (LABA)
   - ☐ Long-acting muscarinic agonist (LAMA)
   - ☐ Leukotriene receptor antagonist
   - ☐ Maximally tolerated ICS/LABA combination product
   - ☐ Medium to high-dose, or maximally tolerated inhaled corticosteroid (ICS)
   - ☐ Other, specify: _____

10. Will patient continue to use asthma controller medication(s) in combination with the requested medication, unless contraindicated? ☐ Yes ☐ No

11. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduced asthma exacerbations, FEV1, reduced hospitalizations)? ☐ Yes ☐ No

For diagnosis of severe asthma with eosinophilic phenotype

12. Was this prescribed by, or in consultation with a provider who specializes in the treatment of severe asthma with eosinophilic phenotype?
    ☐ Yes ☐ No

13. 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

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

15. Provide the following for patient:
    - Percent predicted FEV1: _____% Date taken: _____
    - Absolute blood eosinophil count: _____cells/ µL Date taken: _____

16. Is patient currently being treated with any of the following medications? Check all that apply:
    - ☐ Long-acting beta-2 agonist (LABA)
    - ☐ Long-acting muscarinic agonist (LAMA)
    - ☐ Leukotriene receptor antagonist
    - ☐ High-dose, or maximally tolerated inhaled corticosteroid (ICS)
    - ☐ Other, specify: _____

17. Will patient continue to use asthma controller medication(s) in combination with the requested medication, unless contraindicated? ☐ Yes ☐ No

18. **For depemokimab-ulaa (Exdensur) and mepolizumab (Nucala) requests**, has patient had treatment with any of the following that has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 12 weeks]? Check all that apply:
    - ☐ Benralizumab
    - ☐ Dupilumab
    - ☐ Mepolizumab

☐ Reslizumab

19. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduced asthma exacerbations, FEV1, reduced hospitalizations)? ☐ Yes ☐ No

For diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)

20. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of CRSwNP?
    ☐ Yes ☐ No

21. Does patient have a diagnosis of bilateral sinonasal polyposis confirmed by an endoscopy or computed tomography (CT)? ☐ Yes ☐ No

22. Does patient have any of the following symptoms? Check all that apply:
    ☐ Nasal congestion, blockage, or obstruction with moderate to severe symptom severity
    ☐ Nasal discharge
    ☐ Facial pain or pressure
    ☐ Reduction or loss of smell

23. Does patient have a history of failure, contraindication or intolerance to any of the following? Check all that apply:
    ☐ Oral systemic corticosteroid therapy for 10 to 14 days within the last 24 months
    ☐ Intranasal corticosteroid (minimum trial of two months)

24. Will patient continue to use a intranasal corticosteroid with the use of a monoclonal antibody unless contraindicated? ☐ Yes ☐ No

25. **For mepolizumab (Nucala) requests**, has patient had treatment with any of the following that has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 16 weeks]? Check all that apply:
    ☐ Dupilumab
    ☐ Omalizumab
    ☐ Tezepelumab-ekko

26. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in nasal congestion/obstruction severity, reduction in nasal polyps)?
    ☐ Yes ☐ No

For diagnosis of chronic spontaneous urticaria (CSU)

27. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of CSU?
    ☐ Yes ☐ No

28. Has patient experienced urticaria for ≥ 8 consecutive weeks? ☐ Yes ☐ No

29. Provide patient's Urticaria Activity Score (UAS7):_____ Date taken: _____

30. Has patient tried and failed **TWO** second generation H-1 antihistamines up to maximally tolerated dose or after titration up to 2-4 times FDA approved dose for a minimum of two weeks each, unless all are contraindicated? ☐ Yes ☐ No

31. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in UAS7 score)? ☐ Yes ☐ No

For diagnosis of COPD with eosinophilic phenotype

32. Was this prescribed by, or in consultation with, a provider who specializes in COPD with eosinophilic phenotype?
☐ Yes ☐ No

33. Provide the following for patient:
    - Absolute blood eosinophil count: _____cells/ µL Date taken: _____
    - Percent predicted FEV1: _____% Date taken: _____
    - Number of exacerbations in the last 12 months:
        - Moderate exacerbations: _____
        - Severe exacerbations: _____

34. Is patient currently being treated with any of the following? Check all that apply:
☐ Maximal inhaled therapy (ICS + LABA + LAMA)
☐ Double maintenance therapy (LABA + LAMA) if ICS is contraindicated

35. Has patient had treatment with dupilumab that has been ineffective, contraindicated, or not tolerated [minimum trial of 12 weeks]?
☐ Yes ☐ No

36. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g. improvement in FEV1, dyspnea score, reduced COPD exacerbations)?
☐ Yes ☐ No

For diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)

37. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of EGPA?
☐ Yes ☐ No

38. Does patient have any of the following characteristics typical of EGPA? Check all that apply:
☐ Biopsy showing white blood cells present outside blood vessels (extravascular eosinophils)
☐ Cardiomyopathy
☐ Pulmonary infiltrates
☐ Paranasal sinus abnormality
☐ Mononeuropathy (including multiplex) or polyneuropathy
☐ Glomerulonephritis
☐ Alveolar hemorrhage
☐ Palpable purpura
☐ Anti-neutrophil cytoplasmic antibody (ANCA) positive

39. Does patient have history of asthma and eosinophilia (150 cells/ µL or > 10% of leukocytes)?
☐ Yes ☐ No

40. Does patient have history of relapsing or refractory disease treated with background prednisolone/prednisone without or without immunosuppressive therapy?
☐ Yes ☐ No

41. **For mepolizumab (Nucala) requests** has patient had treatment with benralizumab that has been ineffective, contraindicated, or not tolerated [minimum trial of 1 year]?
☐ Yes ☐ No

42. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduction in relapses, severity or frequency of EGPA-related symptoms)?
☐ Yes ☐ No

For diagnosis of hypereosinophilic syndrome (HES)

43. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of HES?
    ☐ Yes ☐ No

44. Has patient experienced HES for ≥ 6 months? ☐ Yes ☐ No

45. Does patient have a history of ≥ 2 flares in the past 12 months? ☐ Yes ☐ No

46. Does patient have FIP1L1-PDGFRα-negative disease? ☐ Yes ☐ No

47. Does patient have an identifiable non-hematologic secondary cause of HES (e.g., drug hypersensitivity, parasitic helminth infection, HIV, non-hematologic malignancy)? ☐ Yes ☐ No

48. Provide the following for patient:
    - Absolute blood eosinophil count: _____cells/ µL Date taken: _____

49. **For mepolizumab (Nucala) requests** has patient had treatment with benralizumab that has been ineffective, contraindicated, or not tolerated [minimum trial of 1 year]?
    ☐ Yes ☐ No

50. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., decrease in HES flares)? ☐ Yes ☐ No

For diagnosis of IgE-mediated food allergy

51. Was this prescribed by, or in consultation with, a provider who specializes in the treatment of IgE-mediated food allergies? ☐ Yes ☐ No

52. Has patient's diagnosis of IgE-mediated food allergy been confirmed by any of the following? Check all that apply:
    ☐ Food specific skin prick test
    ☐ IgE antibody testing
    ☐ Oral food challenge

53. Has patient been prescribed or has access to epinephrine for emergencies? ☐ Yes ☐ No

54. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

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

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.).