pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IgE, ANTI-TSLP

PRIOR AUTHORIZATION FORM (*form effective 1/9/2023)*

Prior authorization guidelines for Monoclonal Antibodies, Anti-Il, Anti-IgE, Anti-TSLP and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form (pen, vial, etc):
Dose & directions:	Quantity:	Duration: _____ months
Diagnosis:	Dx code (*required*):	Weight: _____ lbs / kg

Has the beneficiary used the requested medication in the past 90 days? *Submit documentation.*	☐Yes – date of last dose: _____ ☐No
Is the requested medication being prescribed by or in consultation with a specialist?	☐Yes ☐No *Submit documentation of consultation, if applicable.*

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

For a non-preferred drug in this class: Does the beneficiary have a history of trial and failure of or contraindication or an intolerance to the preferred agents in this class that are approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents in this class.*	☐Yes ☐No *Submit documentation.*

1. For treatment of ASTHMA:
   - ☐Is currently receiving optimally titrated doses of or has a contraindication or an intolerance to the following (*check all that apply*):
     - ☐inhaled glucocorticoid
     - ☐long-acting beta-agonist (LABA)
     - ☐leukotriene modifier
     - ☐other (eg, tiotropium, theophylline): _____
   - ☐For an anti-IgE MAB (eg, XOLAIR):
     - ☐Has moderate-to-severe persistent asthma induced by an unavoidable perennial allergen (pollen, mold, dust mites, etc)
     - ☐Diagnosis confirmed by positive skin test or radioallergosorbent test (RAST)

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- ☐ Has a serum total IgE measurement between 30 international units (IU)/mL and 1300 IU/mL

☐ For an anti-IL MAB (eg, CINQAIR, FASENRA, NUCALA):

- ☐ Has asthma of an eosinophilic phenotype – Absolute blood eosinophil count: _____/mL Date obtained: _____
- ☐ Has severe asthma

☐ For an anti-TSLP (eg, TEZSPIRE):

- ☐ Has severe asthma

2. For treatment of CHRONIC SPONTANEOUS (IDIOPATHIC) URTICARIA:
   - ☐ Has a history of urticaria for a period of ≥6 weeks
   - ☐ Requires use of systemic steroids to control urticarial symptoms
   - ☐ Tried and failed the maximally tolerated dose of an H1 antihistamine (eg, cetirizine/levocetirizine, fexofenadine, loratadine/desloratadine) taken for at least 2 weeks or has a contraindication or an intolerance to H1 antihistamines

3. For treatment of EGPA:
   - ☐ Has a history of asthma
   - ☐ Has an absolute blood eosinophil count ≥1000/microliter
   - ☐ Has a blood eosinophil level >10% of leukocytes
   - ☐ Has evidence of the following *(check all that apply)*:
     - ☐ histopathological evidence of:
       - ☐ eosinophilic vasculitis
       - ☐ perivascular eosinophilic infiltration
       - ☐ eosinophil-rich granulomatous inflammation
     - ☐ neuropathy (nerve deficit or conduction abnormality)
     - ☐ pulmonary infiltrates, non-fixed
     - ☐ sino-nasal abnormality
     - ☐ cardiomyopathy
     - ☐ glomerulonephritis
     - ☐ alveolar hemorrhage
     - ☐ palpable purpura
     - ☐ positive test for ANCA
   - ☐ Requires systemic glucocorticoids to maintain remission
   - ☐ Has a contraindication or an intolerance to systemic glucocorticoids
   - ☐ Has severe EGPA as defined by national treatment guidelines
     - ☐ Tried and failed or has a contraindication or an intolerance to rituximab or cyclophosphamide

4. For treatment of HYPEREOSINOPHILIC SYNDROME (HES):
   - ☐ Has documented FIP1L1-PDGFRA-negative HES
   - ☐ Has organ damage or dysfunction
   - ☐ Has a blood eosinophil count ≥1000/microliter
   - ☐ Requires or has required systemic glucocorticoids to maintain remission
     - ☐ Has a contraindication or an intolerance to systemic glucocorticoids

5. For treatment of NASAL POLYPS:
   - ☐ Has a history of trial and failure of or contraindication or intolerance to nasal corticosteroids
   - ☐ For an anti-IgE MAB (eg, XOLAIR):
     - ☐ Has a serum total IgE measurement between 30 international units (IU)/mL and 1500 IU/mL

RENEWAL requests

1. For treatment of ASTHMA:
   - ☐ Experienced measurable evidence of improvement in the severity of the asthma condition
   - ☐ Will continue to use optimally titrated doses of or has a contraindication or an intolerance to the following (*check all that apply*):
     - ☐ inhaled glucocorticoid
     - ☐ leukotriene modifier
     - ☐ long-acting beta-agonist (LABA)
     - ☐ other (eg, tiotropium, theophylline): _____

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2. For treatment of CHRONIC SPONTANEOUS (IDIOPATHIC) URTICARIA:
   - ☐ Experienced an improvement in symptoms
   - ☐ Document rationale for continued use: _____

3. For treatment of EGPA:
   - ☐ Experienced measurable evidence of improvement in disease activity
   - ☐ Reduction in use of systemic glucocorticoids for the treatment of EGPA

4. For treatment of HYPEREOSINOPHILIC SYNDROME (HES):
   - ☐ Experienced measurable improvement in disease activity
   - ☐ Reduction in use of systemic glucocorticoids for the treatment of HES

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: