

Request for Prior Authorization

IL-5 ANTAGONISTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

1. Long-acting muscarinic antagonist/anticholinergic (LAMA); and
2. Long-acting beta2-agonist (LABA); and
3. Inhaled corticosteroid (ICS); or
- ii. Double therapy with both of the following if ICS is contraindicated:
 1. LABA, and
 2. LAMA; and
- d. Patient has a history of at least 2 moderate or 1 severe exacerbation(s) in the previous 12 months despite receiving maximal triple therapy or double therapy (defined above). Moderate exacerbation is defined as patient required treatment with systemic corticosteroids and/or antibiotics and severe exacerbation is defined as hospitalization or observation for over 24 hours in an emergency department or urgent care facility; and
- e. Documentation mepolizumab will be used as an add-on maintenance treatment with triple or double therapy (as defined above); and
7. Medication will be administered in the patient's home; and
8. Prescribed by or in consultation with an allergist, hematologist, immunologist, otolaryngologist, 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, 6 months for a diagnosis of hypereosinophilic syndrome or CRSwNP, or 12 months for a diagnosis of COPD 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
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.

Chronic Rhinosinusitis with Nasal Polyps (CRSwNP):

1. Patient has demonstrated positive clinical response to therapy (improvement in symptoms); and
2. Continues to receive medication as add-on maintenance therapy with a nasal corticosteroid spray.

Chronic Obstructive Pulmonary Disease (COPD)

1. Patient has demonstrated positive clinical response to therapy; and
2. Continues to receive add-on maintenance therapy with triple or double therapy (as defined above).

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

Preferred

☐ Fasenna Auto-Injector

☐ Nucala Auto-Injector

☐ Nucala Prefilled Syringe

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis: _____

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

☐ **Yes, document specialty:** _____

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☐ **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

Will the medication be administered in the patient's home? ☐ 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: _____

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-PDGFRα 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: _____

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Does patient have a blood eosinophil count $\geq 1,000$ 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: _____☐ **CRSwNP:**

Will mepolizumab be used as an add-on maintenance treatment with a nasal corticosteroid spray?

☐ No ☐ Yes; Provide Drug Name & Dose: _____

Document at least one preferred drug trial from each of the following categories:

Nasal corticosteroid spray: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial start date: _____

Oral corticosteroid: Drug Name: _____ Strength: _____

Dosing Instructions: _____ Trial start date: _____

☐ **COPD with an eosinophilic phenotype:**

Provide all of the following information:

FEV1/FVC ratio: _____ Date obtained: _____**FEV1 % predicted:** _____ Date obtained: _____**Blood eosinophil count:** _____ Date obtained: _____**Trial information:****LABA Trial:**

Name/dose: _____ Trial dates: _____

Failure reason/medical contraindication: _____

LAMA Trial:

Name/dose: _____ Trial dates: _____

Failure reason/medical contraindication: _____

ICS Trial:

Name/dose: _____ Trial dates: _____

Failure reason/medical contraindication: _____

Document exacerbations:**Moderate:**

Date: _____ Treatment needed: _____

Date: _____ Treatment needed: _____

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Severe:

Date: _____ **Place of care:** _____

Will patient continue to receive maintenance therapy concomitantly with mepolizumab?

☐ Yes ☐ No

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:

- ☐ wheezing
- ☐ chest tightness
- ☐ coughing
- ☐ 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: _____

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: _____

CRSwNP:

Has patient demonstrated a positive clinical response to therapy (improvement in symptoms)?

☐ No

☐ Yes, please describe: _____

Does patient continue to receive medication as add-on therapy with a nasal corticosteroid spray?

☐ No ☐ Yes; Provide Drug Name & Dose: _____

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COPD:

Has patient demonstrated a positive clinical response to therapy?

☐ No ☐ Yes, please describe: _____

Does patient continue to receive add-on maintenance therapy with triple or double therapy?

☐ No ☐ Yes; Provide Drug Name & Dose: _____

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
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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 Health and Human Services, that the member continues to be eligible for Medicaid.