Print Reset

Nebraska Medicaid Program Request for Prior Authorization of Payment
Immunomodulators: Self-Administered Injectables

If the following information is not complete, correct, or legible, the PA process can be delayed. *Please use one form per member.*

Member Information

MEMBER'S LAST NAME:

MEMBER'S FIRST NAME:

MEDICAID NUMBER:

MEMBER'S DATE OF BIRTH: – –

Prescriber Information

PRESCRIBER'S LAST NAME:

PRESCRIBER'S FIRST NAME:

PRESCRIBER'S NPI NUMBER:

DEA NUMBER:

PRESCRIBER'S PHONE NUMBER: – –

PRESCRIBER'S FAX NUMBER: – –

Participating Pharmacy

NAME:

REQUEST DATE

PHARMACY PHONE NUMBER: – –

PHARMACY FAX NUMBER: – –

Please indicate which medication is being requested and complete the information below:
Non-preferred agents require a trial of a preferred agent within this drug class with the same indication

DRUG REQUESTED (Adbry, Dupixent, Fasenra, Nucala, Xolair)

- ☐ Adbry™ (tralokinumab-ldrm)
- ☐ Dupixent® (dupilumab)
- ☐ Fasenra® (benralizumab)
- ☐ Nucala® (mepolizumab)
- ☐ Xolair® (omalizumab) syringe

DRUG NAME:

DRUG STRENGTH:

DOSING SCHEDULE:

QUANTITY PER MONTH:

Diagnosis for use:

- ☐ Allergic Asthma (*see Section G*)
- ☐ Chronic Spontaneous Urticaria (*see Section H*)
- ☐ Chronic Rhinosinusitis with Nasal Polyposis OR Nasal Polyps (*see Section F*)
- ☐ Eosinophilic Asthma (*see Section A*)
- ☐ Eosinophilic Esophagitis (*see Section I*)
- ☐ Eosinophilic Granulomatosis with Polyangiitis (*see Section C*)
- ☐ Hypereosinophilic Syndrome (*see Section D*)
- ☐ Moderate to Severe Atopic Dermatitis (*see Section E*)
- ☐ Oral Corticosteroid-Dependent Asthma (*see Section B*)
- ☐ Prurigo Nodularis (*see Section J*)

FOR INITIAL REQUESTS, SEE SECTIONS A THROUGH J. FOR REAUTHORIZATION REQUESTS, SEE SECTION K.

For current PDL status, please visit: https://nebraska.fhsc.com/downloads/PDL/NE_PDL.pdf

- Medication will not be approved in combination with any other interleukin IL-4, IL-5, or IL-13 antagonists, nor any anti-immunoglobulin E (IgE) antibody.
- Future FDA-approved changes not currently listed on this form will be reviewed based upon the package insert information and any pre-requisite treatment requirements for that indication.

Fax this form to: 866-759-4115
or **mail to**:
Magellan Medicaid Administration, Inc. MAP Dept.
Attention: NE Senior Pharmacist,
4300 Cox Road, Glen Allen, VA 23060
Tel: 1-800-241-8335

Adbry™ (tralokinumab-ldrm)

Treatment of moderate-to-severe atopic dermatitis in adult patients whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable.

Dupixent® (dupilumab)

- Add-on maintenance treatment for moderate to severe eosinophilic asthma or with oral corticosteroid-dependent asthma in patients ≥ 6 years of age
- Treatment of uncontrolled moderate to severe atopic dermatitis in patients ≥ 6 months of age whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable
- Add-on maintenance treatment for inadequately controlled chronic rhinosinusitis with nasal polyposis in adults
- Treatment of eosinophilic esophagitis (EoE) in patients ≥ 12 years of age and weighing ≥ 40 kg
- Treatment of prurigo nodularis in adults

Fasenra® (benralizumab)

- Add-on maintenance treatment for severe eosinophilic asthma in patients ≥ 12 years of age

Nucala® (mepolizumab)

- Add-on maintenance treatment for severe eosinophilic asthma in patients ≥ 6 years of age
- Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) in adult patients 18 years of age and older with inadequate response to nasal corticosteroids
- Treatment of eosinophilic granulomatosis with polyangiitis (EGPA) in adults
- Treatment of patients ≥ 12 years of age with hypereosinophilic syndrome (HES) for ≥ 6 months without an identifiable non-hematologic secondary cause

Xolair® (omalizumab) syringe

- Treatment of moderate to severe persistent asthma with a positive skin test or *in vitro* reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids in patients ≥ 6 years of age
- Add-on maintenance treatment for nasal polyps in adults with inadequate response to nasal corticosteroids
- Treatment of chronic spontaneous urticaria (CSU) in patients ≥ 12 years of age who remain symptomatic despite H1 antihistamine treatment

Initial approval (6 months) will be based on documentation of the following:

SECTION A: EOSINOPHILIC ASTHMA

1. Prescriber attestation of (please check one):
   ☐ Moderate to severe eosinophilic asthma (Dupixent) ☐ Severe eosinophilic asthma (Fasenra, Nucala)
2. Has patient had ≥ 1 exacerbation (oral corticosteroid burst, ER visit, hospital, office visit) in the past 12 months while on, and adherent to, a medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller therapy, OR a max-tolerated inhaled corticosteroid/long-acting beta agonist combo? ☐ Yes ☐ No

   If no, please explain: _____
3. Medication is being prescribed by **OR** in consultation with a:
   ☐ Pulmonologist ☐ Immunologist ☐ Allergist
4. Submit current labs/documentation of the following:
   Baseline blood eosinophil count ≥ 150 cells/µl within the past 6 weeks.

SECTION B: ORAL CORTICOSTEROID-DEPENDENT ASTHMA

1. Does prescriber attest that patient has oral corticosteroid dependency? ☐ Yes ☐ No
2. Does prescriber attest that asthma symptoms are not adequately controlled by prior drug therapy of either medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller, OR a max-tolerated inhaled corticosteroid/long-acting beta agonist combo? ☐ Yes ☐ No

   If no, please explain: _____
3. Medication is being prescribed by **OR** in consultation with a:
   ☐ Pulmonologist ☐ Immunologist ☐ Allergist

SECTION C: EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)

1. Patient has a diagnosis of relapsing or refractory disease with **TWO** of the following (check all that apply):
   - ☐ History or presence of asthma
   - ☐ Eosinophilia (> 10% of total WBCs)
   - ☐ Evidence of 2 or more features of EGPA (biopsy showing histopathological evidence, non-fixed pulmonary infiltrates, cardiomyopathy, alveolar hemorrhage or other standard characteristics)

Please attach current lab work for baseline blood eosinophil count dated within the past 6 weeks.

2. Is patient currently on a stable dose of oral prednisone or prednisolone and has been for at least 4 weeks? ☐ Yes ☐ No

   If no, please explain: _____

3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist ☐ Rheumatologist

SECTION D: HYPEREOSINOPHILIC SYNDROME (HES)

1. Has patient had a diagnosis of HES for ≥ 6 months without an identifiable non-hematologic secondary cause? ☐ Yes ☐ No
2. Has patient had two or more HES flares within the past 12 months? ☐ Yes ☐ No

   Please check ONE of the following criteria:
   - ☐ Worsening of clinical signs/symptoms
   - ☐ Increased eosinophils on ≥ 2 occasions
   - ☐ An increase/addition of oral corticosteroids or cytotoxic or immunosuppressive therapy

3. Does patient have a blood eosinophil count ≥ 1000 cells/µl? ☐ Yes ☐ No

   If no, please explain: _____

Please attach current lab work for blood eosinophil count dated within the past 6 weeks.

4. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist ☐ Hematologist ☐ Cardiologist ☐ Oncologist

SECTION E: MODERATE TO SEVERE ATOPIC DERMATITIS

1. Has patient completed a ≥ 14-day trial of a medium- to high-potency topical corticosteroid to achieve and maintain remission of low or mild disease? ☐ Yes ☐ No

   Dates of trial: _____ to: _____

   If no, please explain: _____

2. Has patient completed a 6-week trial of a topical calcineurin inhibitor? ☐ Yes ☐ No

   Dates of trial: _____ to: _____

   If no, please explain: _____

SECTION F: CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP) OR NASAL POLYPS

1. Does patient have a confirmed diagnosis by evidence of the presence of bilateral nasal polyps by physical examination, rhinoscopy, nasal endoscopy, or diagnostic testing? ☐ Yes ☐ No

***For Xolair syringe: Please attach current lab work for serum IgE levels measured before the start of treatment.*

2. Has patient had an inadequate response or a contraindication to a trial of 1 maintenance intranasal corticosteroid used for at least 8 weeks or a systemic corticosteroid, or has had prior nasal surgery? ☐ Yes ☐ No

   If no, please explain: _____

3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Otolaryngologist ☐ Pulmonologist ☐ Allergist/Immunologist

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SECTION G: ALLERGIC ASTHMA

1. Has patient had moderate to severe persistent asthma with ≥ 1 exacerbation (oral corticosteroid burst, ER visit, hospital, office visit) in the past 12 months while on, and adherent to, a medium- to high-dose or max-tolerated inhaled corticosteroid plus a controller therapy, OR a max-tolerated inhaled corticosteroid/long-acting beta agonist combo? ☐ Yes ☐ No

   If no, please explain: _____

2. Did patient test positive to a perennial aeroallergen? ☐ Yes ☐ No

Please attach lab work for serum IgE levels measured before the start of treatment.

3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Pulmonologist ☐ Immunologist ☐ Allergist

SECTION H: CHRONIC SPONTANEOUS URTICARIA (CSU)

1. Has patient had chronic spontaneous urticaria for at least 3 months? ☐ Yes ☐ No
2. Does patient have a treatment failure, or a contraindication to a four-week trial of a second-generation H_1 antihistamine? ☐ Yes ☐ No
3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Dermatologist ☐ Allergist ☐ Immunologist

SECTION I: EOSINOPHILIC ESOPHAGITIS (EoE)

1. Does patient have a confirmed diagnosis of eosinophilic esophagitis with ≥ 15 eosinophils/high-power field? ☐ Yes ☐ No
2. Does patient have a treatment failure, contraindication, or technique difficulty to a swallowed topical corticosteroid or a proton pump inhibitor? ☐ Yes ☐ No
3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Allergist ☐ Gastroenterologist ☐ Immunologist

SECTION J: PRURIGO NODULARIS

1. Does patient have a confirmed diagnosis of Prurigo Nodularis with provider attestation of ≥ 20 nodular lesions? ☐ Yes ☐ No
2. Does patient have a contraindication or a treatment failure of a medium- to super-potent topical corticosteroid? ☐ Yes ☐ No
3. Medication is being prescribed by **OR** in consultation with a:

   ☐ Dermatologist ☐ Allergist ☐ Immunologist

SECTION K: REAUTHORIZATION (12 MONTHS) WILL BE BASED ON THE FOLLOWING:

See section below for patient's specific diagnosis.

ALLERGIC ASTHMA:

1. Patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):

   ☐ Decreased frequency of exacerbations
   ☐ Decreased use of rescue medication
   ☐ Increase in percent predicted FEV_1 from pre-treatment baseline
   ☐ Decrease in severity of frequency of asthmatic symptoms (wheezing, shortness of breath, coughing)

2. Has patient been compliant with therapy? ☐ Yes ☐ No

SECTION K (*CONTINUED*): REAUTHORIZATION (12 MONTHS) WILL BE BASED ON THE FOLLOWING:

ATOPIC DERMATITIS:

1. Has patient had a positive clinical response to therapy as confirmed by a decrease in severity of symptoms? ☐ Yes ☐ No
2. Has patient been compliant with therapy? ☐ Yes ☐ No

CHRONIC SPONTANEOUS URTICARIA (CSU):

1. Has patient had a positive response to therapy as confirmed by a decrease in severity of symptoms? ☐ Yes ☐ No
2. Has patient been compliant with therapy? ☐ Yes ☐ No

EOSINOPHILIC ASTHMA AND CORTICOSTEROID-DEPENDENT ASTHMA:

1. Patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):
   - ☐ Decreased frequency of exacerbations
   - ☐ Increase in percent predicted FEV_1 from pre-treatment baseline
   - ☐ Decreased use of rescue medication
   - ☐ Decrease in severity or frequency of asthmatic symptoms (wheezing, shortness of breath, coughing)
2. Has patient been compliant with therapy? ☐ Yes ☐ No

EOSINOPHILIC ESOPHAGITIS:

1. Has patient had a positive response to therapy as confirmed by a decrease in severity of symptoms? ☐ Yes ☐ No
2. Has patient been compliant with therapy? ☐ Yes ☐ No

EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA):

1. Patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):
   - ☐ Reduction in relapses
   - ☐ Reduction in glucocorticoid dose
2. Has patient been compliant with therapy? ☐ Yes ☐ No

HYPEREOSINOPHILIC SYNDROME (HES):

1. Patient had a positive clinical response to therapy as confirmed by at least **ONE** of the following (check all that apply):
   - ☐ Reduction in number of flares
   - ☐ Decrease from baseline blood eosinophil count
2. Has patient been compliant with therapy? ☐ Yes ☐ No

NASAL POLYPS OR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSwNP):

1. Has patient had a positive response to therapy as confirmed by a decrease in severity of symptoms? ☐ Yes ☐ No
2. Has patient been compliant with therapy? ☐ Yes ☐ No

PRURIGO NODULARIS:

1. Has patient had a positive response to therapy as confirmed by a decrease in itch intensity or a decrease in number of nodules? ☐ Yes ☐ No
2. Has patient been compliant with therapy? ☐ Yes ☐ No

Prescriber Signature (Required) _____ ***Date*** _____

(By signing, the prescriber confirms that the above information is accurate and verifiable by patient records.)

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